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Counselling and the Professional: Vicarious Trauma, Burnout and Rewards from Clinical Practice

by

Michaela A. Kadambi

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment for the degree of Doctorate of Philosophy

in

Counselling Psychology

Department of Educational Psychology

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Michaela A. Kadambi
4572 Turner Square
Edmonton, Alberta
T6R 3E4

Sept 8/03

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Counselling and the Professional: Vicarious Trauma, Burnout and Rewards from Clinical Practice by Michaela A. Kadambi in partial fulfillment of the requirements for the degree of Doctorate of Philosophy in Counselling Psychology.

Dr. Derek Truscott

Dr. Gretchen Hess

Dr. Wendy Austin

Dr. Fern Snart

Dr. Len Stewin

Dr. Stephen Fleming

Date approved by thesis committee: Aug 28, 2003

Abstract

Three papers relating to the enriching and detrimental aspects of providing counselling on mental health professionals are presented in this dissertation. The first paper reviewed current literature surrounding the phenomenon of vicarious trauma among mental health professionals. This examination revealed that further investigation was needed to examine the applicability of the construct among professionals working outside the area of trauma and to clearly differentiate vicarious trauma from burnout. It was suggested by the review that the majority of mental health professionals cope well with the demands of their work, yet little research has been undertaken to understand this resilience. To address these issues, two separate empirical studies were conducted. The first study was a quantitative investigation of trauma related distress, burnout and spiritual health among three groups of professionals (N=221) providing counselling to individuals affected by sexual violence, cancer diagnoses or students at university counselling centers. Participants completed four dependent measures: The Traumatic Stress Institute Belief Scale – Revision M, the Impact of Events Scale, the Maslach Burnout Inventory and the Spiritual Well Being Scale. Contrary to expectations, no significant differences were found between groups on dependent measures. The findings from this study highlighted concerns related to the construct and divergent validity of vicarious trauma. The second study was a concept mapping investigation of professionals' experience of reward in working with sex offenders. A concept map depicting professionals' experience of the rewarding aspects of sex offender treatment was developed to clarify the domain and scope of their experience. A central belief regarding the effectiveness of treatment connected the seven distinct cluster themes that were identified. Practices to facilitate

rewarding aspects of treating sex offenders were proposed and ideas for additional research were presented. Commonalities noted between the two empirical studies were the apparent importance of social and collegial support in mitigating the negative aspects of providing counselling and the likely role of empathy as a key determinant in professionals' responses to clinical practice. Future research investigating how empathic connections influence professionals' responses to their work may contribute to a more comprehensive and balanced understanding of the positive and negative repercussions of providing counselling.

Acknowledgements

This project has been such a joy. In talks with friends and colleagues, I have often heard parallels drawn between giving birth and writing one's dissertation. Indeed, at the end of this journey I do have a sense of laboring and breathing life into this project and looking back, have struggled tremendously at times with the process of writing. I wonder if there is truth to what many mothers have said - that they have forgotten all about the pain...

I am quite sure that part of my fondness toward this research project has to do with the fact that it very directly led me to meeting another graduate student from the University of Memphis who conducted similar research. I never would have guessed that this research would lead me to a husband in addition to a Ph.D.! Deep thanks goes to my adored husband, friend and incredible colleague Dr. Liam Ennis. Liam and I wrote our respective dissertations at the same time in different countries in the midst of my new job, his internship, buying our first home and planning a wedding. Somewhere in between, we managed to remain emotionally connected across 2700 miles, motivate and encourage one another in the dissertation process. I cannot thank him enough for his support, humor, editing skills, and fresh perspective when I was lost in mine. You have not only my love, but have my professional respect and admiration.

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I have had the good fortune to work with each of the client populations to which the participants in these studies provided clinical services. There are clients to whom you cannot help extend a genuine feeling of care and love in addition to your professional skills. A deep sense of gratitude goes out to those clients whose strength, resilience and sorrow left a permanent impression on me. Although some of these individuals have died, I practice many life lessons learned from these clients. I thank the following people; Robin, Alice, Michael, Elizabeth, Rae, Grace, Valerie, Candace, James, Kristen, Lynn and Bill; whose faces and life stories I will always remember with a sense of fondness and privilege.

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CHAPTER 1

INTRODUCTION

Background to the Research

In 1990, following their observations and clinical work with survivors of interpersonal violence, McCann and Pearlman developed the construct of "vicarious trauma" to describe the cumulative and unique effects of trauma work on mental health professionals. Vicarious traumatisation refers to the process by which the inner experience of the therapist is negatively affected through empathic interactions with clients who have been exposed to violent trauma. The phenomenon produces disruptions in cognitive schemas associated with safety, trust, power, control, and intimacy, in addition to sub-clinical symptoms of post-traumatic stress disorder (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). Although these effects have been conceptualized as a normal, inevitable and cumulative response to trauma work, therapists experiencing this phenomenon may become emotionally and professionally impaired in ways that can negatively affect the quality of the psychotherapeutic services they provide (Pearlman, 1995; Pearlman & Saakvitne, 1995b).

Since its inception, the term vicarious trauma has fast become a popular way to describe the overall effects of working with trauma on mental health professionals. Although the construct offers a framework from which to understand how mental health professionals can be affected by their emotional connection with the trauma of others, research in this area is still in its infancy. Several key issues relating to the theory behind the construct, how it is measured, how the construct is distinct from other phenomena and which professionals are most vulnerable, remain unresolved.

Despite the intuitive appeal the construct has for clinicians, research investigating the impact of providing counselling to traumatized populations has not consistently supported the notion that professionals working in the area of trauma are at significant risk for profoundly negative consequences due to their work. In fact, the majority of professionals working in the area of trauma are coping well with the demands of their clinical work on both personal and professional levels (Brady, Guy, Poelstra, Fletcher Brokaw, 1999; Ellerby, 1998; Ennis & Horne, 2003; Kadambi, 1998). Comparatively little attention has been given to investigating and identifying personal/professional characteristics or work-related variables that account for this emotional wellness, as opposed to vicarious trauma, in the practice of clinical work.

The investigations that comprise this dissertation are part of a program of research intended to investigate the positive and negative experiences of professionals providing counselling to a variety of client populations. This research attempts to address the aforementioned deficits in existing literature surrounding the phenomena of vicarious trauma. In contrast to the detrimental effects professionals may experience from their clinical work, additional research was conducted to clarify and identify enriching aspects of clinical work. Specifically, the experience of meaning and reward among a group of professionals working with a client population identified as being particularly challenging was examined.

Overview of Study

Several avenues of research were pursued to explore aspects of the impact of providing counselling on professionals. Initially, review of the theory and research associated with vicarious trauma was conducted to identify important areas of further

research. Two key themes emerged from this examination of current research. The first was a need to investigate the construct validity of vicarious trauma and to explore the phenomena as it applied to professionals working with different client populations. The second theme was a clear lack of empirical investigation and explanation for the finding that the majority of professionals identified as being particularly vulnerable to the experience of vicarious trauma were, in fact, coping well with the demands of clinical work.

To address these themes, two related empirical investigations were conducted to further explore the impact of providing counselling to a variety of client populations. The first study was intended to explore the phenomena of vicarious trauma among professionals providing counselling to one of three client populations. Two of the three groups of professionals in this study provided services primarily to individuals who had experienced a traumatic stressor associated with either sexual violence or a cancer diagnosis, respectively. A third group of professionals who were identified as not working primarily with trauma, but with clients who have a range of presenting issues, was used as a comparison group.

Participants completed four dependent measures. The Traumatic Stress Institute Belief Scale – Revision M (TSI; Pearlman, 1996) assessed cognitive disruptions associated with vicarious trauma. In conjunction with the TSI, the Impact of Event Scale (IES; Horowitz, Wilner & Alvarez, 1980) was used to assess trauma related symptomatology. Participants also completed the Spiritual Well Being Scale (SWB; Ellison & Smith, 1991) and the Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996) to assess levels of existential and religious well being and aspects of

professional burnout. The purpose of this investigation was to identify predictive factors in the subsequent development of vicarious trauma and burnout, and to clarify the relationship between these two constructs. The divergent validity of the TSI, which purports to measure vicarious trauma, was also investigated.

The second study was designed to investigate an aspect of wellness associated with clinical work among a group of mental health professionals. Professionals providing treatment to sex offenders have been consistently identified by researchers as being particularly at high risk for experiencing a variety of negative consequences to their work including vicarious trauma and burnout (Bird Edmunds, 1997, Ellerby, 1997; 1998; Farrenkopf, 1992; Hill, 1995; Kearns, 1995; Layton, 1988; Mitchell & Melikian, 1995; Rich, 1997). In spite of the numerous challenges associated with this type of work, these professionals have surprisingly, yet consistently, reported a sense of purpose, meaning and optimism with respect to their clinical work (Ellerby, 1998; Farrenkopf, 1992; Kadambi, 1998). Combining qualitative and quantitative methodology, a concept mapping investigation was undertaken to more fully understand these professionals' experience of reward in providing treatment services to sex offenders. This study was conducted with the intention of clarifying the domain of these professionals' experience of reward from their clinical work and to generate possibilities/directions for future research investigating contributing factors in the development of a sense of wellness and prevention of adverse responses in providing sex offender treatment.

Format of Dissertation

This thesis consists of five chapters. In Chapter 1, I provide the rationale for this research project, including background information on the research area and the purpose

of the study. I then offer a critical review of the conceptual and empirical difficulties associated with vicarious trauma in Chapter 2. Written primarily for researchers investigating the effects of providing therapy to trauma survivors, this chapter is intended to call attention to concerns regarding divergent validity, sampling bias, psychometric difficulties and premature generalization of findings associated with research involving vicarious trauma. This chapter also highlights the significant implications and need for empirically sound research in this area.

Presented within Chapter 3 are the findings of an empirical investigation examining the phenomena of vicarious trauma and burnout among professionals providing counselling and/or psychotherapy to three different client populations. This chapter reviews the merits and limitations of the construct of vicarious trauma and discusses the larger implications of the research findings. Chapter 4 contains the results and implications from a study exploring professionals' experience of reward and meaning in working with sex offenders. A concept map of these professionals' experience is developed to further understand and identify areas of reward and protective factors in the development of vicarious trauma and burnout among this at risk professional group. A summary of the findings from previous chapters and the collective implications of this research are the focus of the material included in Chapter 5.

In order to facilitate the efficient dissemination of the information obtained through this research project, a paper thesis format will be used. In accordance with University of Alberta guidelines, this dissertation will contain three papers of publishable quality. Chapters 2, 3 and 4 within the dissertation chapters correspond with the three

empirical papers. The paper contained in Chapter 4 has been submitted and is under review for publication in a peer reviewed journal.

Contributions of the Research

Several aspects of this research project ensure an original contribution to the field of Counselling Psychology. Sampling procedures and the inclusion of a control group sets the first study apart from previous studies investigating vicarious trauma, which have relied almost exclusively upon convenience sampling. Previous research in this area has been hampered by the inconsistent use of self-report measures assessing vicarious trauma symptoms and lack of appropriate comparison groups. Researchers to date have also failed to clearly differentiate vicarious trauma from burnout. (Neumann & Gamble, 1996; Schauben & Frazier, 1995). Attention to data collection methods, assessment measures and appropriate statistical analyses used in this study are attempts to remedy these extant difficulties and provide stronger empirical evidence that the constructs are distinct.

The second study investigating professionals' experience of reward and meaning in working with sex offenders represents an investigation of the positive impact of working with difficult populations on helping professionals. This study represents the first direct investigation into personal and professional rewards for those providing treatment services to sex offenders. Previous references to a sense of enjoyment, meaning or reward from working with this client population has been almost exclusively anecdotal and has been reported in the context of investigating the challenges of clinical work with sex offenders (Bird Edmunds, 1997; Farrenkopf, 1992; Mitchell & Melikian, 1995; Rich, 1997).

Whether one provides counselling primarily to sex offenders, survivors of traumatic stressors or other client populations, the possibility of experiencing deleterious cognitive and affective reactions as a result of working intensely with people in a therapeutic context, certainly exists. Perhaps in coexistence with these experiences, clinical work also provides professionals with a great sense of meaning, purpose and serves to energize, challenge, excite and replenish the spirit. It is hoped that collectively, these investigations will contribute to a more balanced understanding of how, why, and which professionals are negatively and/or positively affected as a result of their clinical work.

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CHAPTER 2

Vicarious Trauma: A Critical Review

Background

Introduction

In 1990, McCann and Pearlman proposed the concept of vicarious trauma to account for a unique collection of negative experiences among therapists providing therapy to survivors of sexual violence. Although the intuitive appeal of the construct has prompted several attempts at assessing and understanding the experience of vicarious trauma, research in this area to date has been plagued by lack of baseline data, disparate results and methodological limitations. It is the writer's intention in this paper to provide a critical examination of the construct of vicarious trauma, to review key research in this area and offer directions for further areas of inquiry and investigation.

Stressors Facing Psychotherapists

The challenges facing professionals providing psychotherapy have been well documented. Throughout their clinical practice, professionals face a multitude of stressors associated with factors intrinsic to the nature and dynamics of therapy and dealing with challenging client behaviors (Deutsch, 1984; Farber, 1983; Farber & Heifetz, 1981, 1982; Hellman & Morrison, 1987; Hellman, Morrison & Ambramowitz, 1987; Moore & Cooper, 1996; Radeke & Mahoney, 2000; Raquepaw & Miller, 1989). Offering support and assistance to those coping with emotional pain, instability or crisis, can significantly tax the emotional energy and coping resources of professionals providing therapy (Farber & Heifetz, 1981, 1982; Maslach, 1982; Savicki & Cooley, 1987). External influences such as caseloads, social support, working environments and the new realities of managed

care also impact the helping professional's ability to manage the personal and professional demands of their work (Farber & Heifetz, 1981, 1982; Pines & Maslach, 1978; Raquepaw & Miller, 1989; Savicki & Cooley, 1987; Trudeau, Russell, de la Mora & Schmitz, 2001). In addition to the inherent and environmental challenges common to professionals providing psychological services, professionals working with clients who have experienced trauma appear to face stressors that are specific to their clientele (Haley, 1974; Herman, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). The unique aspects of trauma therapy are increasingly being recognized for their potential to produce adverse effects in trauma professionals that appear to be qualitatively different than their counterparts providing services to other client populations (Figley, 1995; Haley, 1974; Herman, 1992; Kassam-Adams, 1995; McCann & Pearlman, 1990; Neuman & Gamble, 1995; Schauben & Frazier, 1995).

Descriptive reports suggest many professionals working with trauma clients are significantly affected by clients' descriptions of traumatic events and human cruelty in ways that can produce profound changes in who they are, the way they work and how they see and behave in the world (Black & Weinreich, 2000; Haley, 1974; Herman 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Schauben & Frazier, 1995). Researchers investigating the effect that work with traumatized clients has on therapists have suggested that these professionals may also experience intrusive and avoidant symptoms similar to post traumatic stress disorder, but at sub-clinical levels (Arvay & Uhlemann, 1996; Brady, Guy, Poelstra & Fletcher Brokaw, 1999; Chrestman, 1995; Pearlman & MacIan, 1995; Schauben & Frazier, 1995).

Defining Vicarious Trauma

The term vicarious trauma was first used by McCann and Pearlman (1990), to describe the unique effect of trauma work on trauma therapists. Vicarious trauma describes the process and mechanism by which the inner experience of the therapist is profoundly and permanently changed through an empathic bonding with the client's traumatic experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). Three conditions within the therapeutic dynamic largely specific to clinical work with trauma survivors have been theorized to facilitate this empathic bonding and produce the experience of vicarious trauma. The three conditions include: 1) empathic engagement and exposure of the therapist to graphic and traumatic material, 2) empathic engagement and exposure of the therapist to the reality of human cruelty and 3) the therapists' participation in traumatic re-enactments wherein client transference responses re-enact elements of the initial trauma within the therapy process (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a).

The construct itself is conceptualized within constructivist self-development theory (CSDT). Combining psychoanalytic, social learning and cognitive development theories, the underlying principle of CSDT understands individuals' responses to trauma as an adaptation that is determined by the characteristics of the individual, the nature and dynamics of the traumatic stressor and the socio-cultural environment within which the stressor is experienced (McCann & Pearlman, 1995; Pearlman & Saakvitne, 1995a). A central feature of CSDT is that all individuals possess cognitive schema that develop as a result of our socialization experiences. These schemas reflect beliefs and expectations about the self, others and the world in which we live (Janoff-Bulman, 1992). These

fundamental schemas assist us in organizing and interpreting our subsequent experiences. It is suggested that certain psychological need areas (safety, trust, power, control and intimacy) and the corresponding schemas are significantly affected by the experience of trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). In the context of providing trauma therapy, the therapist's cognitive schemas are disrupted as a result of their exposure to the trauma of their clients, which, in turn leads to the symptomatology (affective, behavioral and interpersonal responses) of vicarious trauma.

Due to interactions between individual therapist characteristics and the characteristics of their work and work setting, the experience of vicarious trauma is thought to be a unique for each individual. However, commonalities have been proposed to exist across the collective experiences of those affected by vicarious trauma. Vicarious trauma is thought to produce changes in the therapist's sense of spirituality, worldview, self-identity in addition to disruptions in cognitive schemas associated with trust, intimacy, safety, power and control (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). Sub-clinical symptoms of posttraumatic stress disorder (PTSD) also hallmark the experience of vicarious trauma among professionals involved in trauma work (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a).

Differentiating Vicarious Trauma

There are presently many ways of conceptualizing the impact of therapy on the helping professional. The field has not, however, reached a consensus on the identification of a single descriptor that accurately reflects the uniqueness and range of responses to providing trauma therapy. Furthermore, theorists have not yet arrived at an agreed upon explanation that accounts for how and why these professionals may be affected by their

work. Counter-transference (McCann & Pearlman, 1995; Wilson & Lindy, 1994), burnout (Freudenberger 1974; Maslach, 1982), and compassion fatigue (Figley, 1995; Joinson, 1992) all offer ways for us to understand how professionals respond to their clinical trauma work. Although there are proposed relationships between these constructs, vicarious trauma is thought to be distinct (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a).

In contrast with countertransference which most commonly describes therapists' affective, cognitive and behavioral responses to specific clients (Jacobs, 1991; Maroda, 1991), vicarious trauma refers to the therapist's cumulative emotional, cognitive and behavioral and responses across all clients (McCann & Pearlman 1990; Pearlman & Saakvitne, 1995a). Although distinct, vicarious trauma and counter-transference are thought to influence one another. Pearlman & Saakvitne (1995a) state; "Vicarious traumatisation represents changes in the most intimate psychological workings of the self of the therapist. The self of the therapist is the context for all of her countertransference responses. Thus, vicarious traumatisation invariably shapes countertransference... As a therapist experiences increasing levels of vicarious traumatisation her countertransference responses can become stronger and/or less available to conscious awareness" (p. 33-34).

It has been proposed that the experience of vicarious trauma is also distinct from the experience of burnout. Burnout commonly refers to a syndrome of symptoms that include emotional exhaustion, disconnection from clients and a lack of sense of accomplishment in one's work (Maslach, 1982; Maslach, Jackson, & Leiter 1996). Burnout is commonly thought be the result of work related variables that make it difficult for the mental health professional to meet emotional, physical and mental demands of their work (Cherniss,

1992; Freudenberger, 1974; Maslach, Jackson & Leiter 1996). Furthermore, burnout is considered to be transient and preventable (Maslach, 1982; Pearlman & Saakvitne, 1995a). Vicarious trauma, however, is considered to be a phenomenon that is unique to mental health professionals working with traumatized clients, and it is considered to be an inevitable and permanent consequence of clinical work with this client population (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). Proponents of the vicarious trauma construct further suggest that the experience of burnout does not accurately or sufficiently reflect the profound internal changes and traumatic stress symptoms that trauma therapists may experience as a consequence of clinical work (McCann & Pearlman, 1990; Schauben & Frazier, 1995). Moreover, the effects of burnout are typically considered to be limited to the work environment, while the effects of vicarious traumatisation extend well beyond the workplace into all realms of the individual's life. McCann and Pearlman (1990) state that for trauma therapists, the symptoms of burnout may be "...the final common pathway of continual exposure to traumatic material that cannot be assimilated or worked through" (p. 134). By this rationale, vicarious trauma and burnout may be said to represent constructs that are somewhat overlapping, but that are nonetheless distinct.

Perhaps most similar to the concept of vicarious trauma is that of compassion fatigue or secondary traumatic stress (Figley, 1983; 1995a). Figley (1995b) defines compassion fatigue as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 10). The observable symptoms associated with compassion fatigue are highly similar to those

associated with vicarious trauma. These include intrusive and avoidant symptoms that parallel the experience of the direct trauma survivor, in conjunction with feelings of emotional depletion, helplessness and isolation (Figley, 1995a, 1995b).

In contrast to vicarious trauma, which is proposed to be an inevitable, irreversible consequence of working with trauma survivors, the experience of compassion fatigue is conceptualized as an expected, yet, treatable and preventable by-product of working with people who are suffering (Figley, 1995b). The experience of compassion fatigue results from empathizing with those who are experiencing emotional pain and suffering. It is therefore not inextricably bound to the notion that the exposure to descriptions of traumatic events and human cruelty is a necessary condition to produce stress symptoms in therapists. Consequently, compassion fatigue is quite applicable to trauma therapists, but is easily generalized to mental health professionals working with a variety of client populations

What primarily distinguishes vicarious trauma from former elucidations is that this conceptualization attempts to acknowledge and explain the manner in which the therapist may experience changes in the way he/she views, experiences, and interacts with the world, as a result of his/her clinical work (McCann & Pearlman, 1990; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995a, 1995b). Pearlman and Saakvitne (1995a) argue that conceptualizations like burnout and compassion fatigue are limited in that they only offer descriptions of therapists' presenting symptoms and do not account for the internal changes experienced by the therapist. Grounded in CSDT theory, vicarious trauma presents a framework from which to understand the etiology of the experience and

account for the variation of responses among professionals working with traumatized clients (McCann & Pearlman, 1990).

Since it's inception, vicarious trauma has sparked a flurry of discussion and investigations. The construct appears to have great appeal for clinicians, and it has increasingly been applied to a widening scope of professionals (e.g. nurses, emergency service workers) who interact and empathically engage with trauma survivors (Clark & Gioro, 1998; Goldenberg, 2002; Lowe, 2002; Pearlman & Saakvitne, 1995a; Robinson, Clements & Land, 2003; Wasco & Campbell, 2002). Collectively, this small body of research has led to calls for remedial strategies at both the individual and organizational levels aimed at ensuring professional wellness and adaptive coping (Neuman & Gamble, 1995; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995b). The concept of vicarious trauma has, however, been so warmly embraced by mental health community that the publication of remediation and self-care strategies has preceded the performance of empirical research investigating the occurrence and etiology of the phenomenon (Sabin-Farrell & Turpin, 2003)

If one suspends the intuitive allure of the construct and looks at the body of research in this area with a discerning eye, it becomes clear that the importance, prevalence and severity of vicarious trauma may be overstated. Consequently, discussions regarding interventions to address vicarious trauma may be pre-mature. A critical review of the relevant research reveals that the very existence of the phenomenon has not clearly nor consistently been supported among professionals working with traumatized populations (Kadambi, 1998; Sabin-Farrell & Turpin, 2003). The research that has been conducted in this area has lacked empirical rigor and is complicated by problems related to the

operationalization/measurement of vicarious trauma, and has been hindered by findings of inconsistent conceptual and empirical support for the construct. The absence of empirical support for vicarious trauma has not deterred researchers from making continued efforts to validate the construct, and interpret otherwise benign findings to be indicative of support. The present lack of critical dialogue and discussion among researchers appears to be perpetuating a body of research that is based primarily on relational assumptions and a construct with questionable validity (Sabin-Farrell & Turpin, 2003). The limitations associated with this body of research are presented below and are further explored through a critical examination of extant research and discussion of the observed trends in the study of vicarious trauma.

Measurement Difficulties and Inconsistencies

Assessing Vicarious Trauma

Although the challenges of providing psychotherapy to trauma survivors are well documented, the prevalence and degree to which therapists may experience vicarious trauma and traumatic stress symptoms continues to elude researchers. Initial research into the construct has relied primarily on descriptive reports and assessment of intrusive and avoidant symptoms of traumatic stress (Sabin-Farrell & Turpin, 2003; Sexton, 1999). Qualitative studies that have been conducted have been quite consistent in suggesting that the experience and symptoms of vicarious trauma is widespread and significant for many professionals working with traumatized clients (Black & Weinreich, 2000; Iliffe & Steed, 2000; Steed & Downing, 1998). Quantitative investigations, however, have not been as uniform in finding support for a widespread collective phenomenon of trauma related distress among mental health professionals. Some researchers investigating the effects of

providing trauma therapy on professionals have reported support for the notion that treating survivors of trauma result can result in symptoms of traumatic stress and other psychological repercussions in professionals providing treatment (Chrestman, 1995; Cornille & Meyers, 1999; Kassam-Adams, 1995; Munroe, 1991; Schauben & Frazier, 1995). Other researchers, however, have not found this aversive relationship between therapist contact with trauma survivors and traumatic stress symptoms (Baird & Jenkins, 2003; Follett, Polusny & Milbeck, 1994; Jenkins & Baird, 2002; Mauldin, 2001).

Operationalizing and Measuring Vicarious Trauma

Vicarious trauma among mental health professionals has been assessed by researchers in a number of ways, ranging from simple self-indentification (Rich, 1997) to phenomenological analysis (Goldenberg, 2002; Illife & Steed, 2000; Steed & Downing, 1998; Wasco & Campbell, 2002), to the use of questionnaires that measure cognitive/affective/behavioral symptoms associated with trauma related distress (Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Quantitative researchers have typically used questionnaires to assess traumatic stress symptoms such as the Impact of Events Scale (Horowitz, Wilner & Alvarez, 1980) or the Trauma Symptom Checklist –40 (Elliot & Briere, 1992) in conjunction with other measures assessing the cognitive aspects of vicarious trauma. The Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1986) has frequently been included with these measures to assess and differentiate trauma related distress and general distress in samples (Adams, Matto & Harrington, 2001; Brady, Guy, Poelstra, & Fletcher Brokaw, 1999; Kadambi, 1998; Schauben & Frazier, 1995).

Pearlman and MacIan (1995) conducted the first study that attempted to operationalize and measure vicarious trauma. The Traumatic Stress Institute Belief Scale

Revision L (TSI; Pearlman, 1996) was developed and used to assess the cognitive disruptions in psychological need areas (safety, trust, control, intimacy and power) that have been proposed by CSDT as being sensitive to trauma. Disruptions in these cognitive schemas assessed by the TSI were considered to reflect the presence of vicarious trauma. In this study, the TSI was used in conjunction with measures of traumatic stress symptoms and general distress among 188 mental health professionals attending a trauma training workshop. Pearlman and MacIan (1995) reported that therapists with personal histories of trauma and those with the least clinical experience showed higher levels of cognitive disruptions (higher scores on the TSI) suggestive of vicarious trauma and higher levels of general distress compared to other therapists in their sample.

The study conducted by Pearlman and MacIan (1995) is one of the most commonly cited investigations in support of the occurrence of vicarious trauma among professionals working with trauma survivors (Sabin-Farrell & Turpin, 2003). Often overlooked is the fact that results from this study fail to support a clear link between therapists' exposure to trauma via their client caseload and disruptions in cognitive schemas. Sabin-Farrell and Turpin (2003) point out that counter-intuitively, the results of Pearlman and MacIan's (1995) study actually suggest that a higher proportion of survivors on therapists' caseloads was associated with fewer rather than greater disruptions in beliefs as measured by the TSI.

Although the development of the TSI has prompted quantitative research into the extent and degree of vicarious trauma among therapists, the measure itself appears to have significant limitations and has yielded conflicting research findings (Adams, Matto & Harrington, 200; Kadambi 1998; Sabin-Farrell & Turpin, 2003). The contention that

exposure to clients' traumatic material produces disruptions in the cognitive schema assessed by the TSI has not been consistently supported. While some researchers have reported positive relationships between exposure to trauma work and TSI scores (Kassam-Adams, 1995; Schauben & Frazier, 1995), others have failed to do so (Birk, 2002; Brady et al 1999; Trippany, 2001). Some researchers who have included additional measures of traumatic stress in their studies to supplement the TSI have indeed found the expected relationship between traumatic stress symptoms and the therapists' amount of exposure to trauma material on these additional measures. However, these studies have failed to find corresponding elevations on the TSI, which are purported to reflect the cognitive disruptions that are said to be indicative of vicarious trauma, (Birk, 2002; Brady et al, 1999).

TSI Criterion Group Concerns

Pearlman (1996) has reported data on the TSI for several different criterion groups, including mental health professionals. In some cases, the data has been used for comparison purposes to make conclusions regarding the presence and extent of vicarious trauma in participant samples (Pearlman & MacIan, 1995). This may, however, be quite pre-mature. Extant information regarding criterion reference group scores for mental health professionals on the TSI (Pearlman, 1996) suggests that previous exposure to trauma (either primary or secondary) was not adequately controlled. The criterion group of mental health professionals is composed of individuals who were surveyed with the TSI at a trauma training workshop and from the reported scores from other researchers' samples that appear to have primarily investigated therapists working in the area of trauma (Pearlman, 1996). This presents the possibility of inflated scores for these comparison

groups and dictates the need for establishing a comparison group of professionals providing counselling when personal and professional exposure to trauma is adequately assessed and controlled (Kadambi, 1998; Sabin-Farrell & Turpin, 2003). Ultimately, there are no baseline data for the TSI that reflects how the "typical" mental health professional performs on the measure that could provide information on both the validity of vicarious trauma among particular professional groups and the degree to which they are affected.

Unsettled Divergent Validity Issues

Conceptually, vicarious trauma and burnout are related, but distinct constructs (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Schauben & Frazier, 1995). Schauben and Frazier (1995) authored the most commonly cited study supporting the notion of distinctiveness between the constructs. This study investigated vicarious trauma, burnout and traumatic stress symptoms among 148 counsellors working with sexual violence survivors. The distinctiveness of the two constructs was proposed to be supported by the finding that the percentage of survivors on a therapists' caseload was unrelated to measures of burnout, but was related to levels of cognitive disruption assessed by the TSI and measures of traumatic stress symptoms (Schauben & Frazier, 1995). While the results of this study may lend some conceptual support, other researchers have suggested significant overlap between the experience vicarious trauma and burnout (Adams, Matto & Harrington, 2001; Gildwell, 2001; Kadambi, 1998). As well, the results of this study do not resolve the psychometric problems associated with differentiating the two constructs on the basis of their established and frequently used measures, the TSI and MBI.

In a recent landmark study, Jenkins and Baird (2002) examined the concurrent, discriminant and construct validity of instruments designed to assess compassion fatigue, vicarious trauma and burnout. These researchers explored relationships between 4 measures administered to 99 counsellors working in sexual assault and domestic violence agencies. Participants completed the Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996) to assess burnout, the Compassion Fatigue Self Test (CFST; Figley, 1995a) to assess compassion fatigue, the Traumatic Stress Institute Belief Scale – Revision L (TSI; Pearlman, 1996) to assess vicarious trauma and finally the Symptom Checklist (SCL-90-R; Derogatis, 1983) to assess general distress. Results showed evidence of good concurrent and construct validity for the TSI and CFST, but strong convergence with general distress. Jenkins and Baird (2002) reported good discriminant validity from burnout for the CFST and TSI based on the finding that these measures were correlated more strongly with one another than either was with the MBI.

While this study represents a highly important first attempt at examining the construct and divergent validity of the TSI, correlational data from other researchers that have used the TSI and MBI in conjunction with other measures of traumatic stress have reported significant overlap between burnout and vicarious trauma (Adams, Matto & Harrington, 2001; Kadambi, 1998). Contrary to the rationale and hypothesis of Baird and Jenkins (2002), these researchers have found higher correlations between the TSI and MBI compared to correlations between the TSI and measures of traumatic stress (Adams, Matto & Harrington, 2001; Kadambi, 1998).

Methodological Limitations

Lack of Comparison Groups and Control for Confounding Variables

Much of the research that has been conducted on vicarious trauma has been the limited by the absence of comparison groups and lack of control over potentially confounding variables (Kadambi, 1998; Sabin-Farrell & Turpin, 2003). Very few studies have supported the notion that vicarious trauma is unique to trauma therapists by comparing mental health professionals working primarily with trauma clients to their professional counterparts working with other client populations (Kassam-Adams, 1995). Even when this has been attempted, variables that could impact the cognitive disruptions of vicarious trauma and traumatic stress symptoms have not been well controlled, making comparisons potentially invalid (Sabin-Farrell & Turpin, 2003).

This appears to be particularly relevant if one considers research that suggests therapists working with trauma survivors appear to have higher incidences of personal trauma themselves as compared to both the general population and colleagues working with other client populations (Follette, Polusny & Milbeck, 1994; Pearlman & MacIan, 1995; Pope & Feldman-Summers, 1992). Although some professionals working with trauma survivors may experience higher levels of traumatic stress and disrupted cognitive schemas, this may interact with their own history of personal trauma and other work related variables. Qualitative differences and elevated levels of trauma related distress reported by trauma therapists may, in fact, be attributable to a higher incidence of direct trauma rather than the result of vicarious exposure to the trauma of others.

A history of personal trauma has been the most commonly investigated therapist variable in predicting vicarious trauma (Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Research relating to this, however, has been marked by inconsistency with some researchers reporting increased levels of traumatic stress and vicarious trauma among

therapists with a trauma history (Cunningham, 1996; Kassam-Adams, 1995; Lugris, 2001; Pearlman & MacIan, 1995), and others reporting no relationship between therapist distress and trauma history (Adams, Matto & Harrington, 2001; Follette, Polusny & Milbeck, 1994; Schauben & Frazier, 1995; Trippany, 2001). As such, it remains unclear as to how therapists own personal history of trauma may contribute to the experience of vicarious trauma.

Validity of Self Report

Contributing to concerns about the valid assessment of vicarious trauma are related concerns regarding the validity of therapists' self report. Both qualitative and quantitative research is reliant on the professionals' ability to identify and report trauma related distress that is associated with clinical trauma work. Steed and Downing (1998) conducted a qualitative investigation into the effects of listening to traumatic material, perceived effects of vicarious trauma and cognitive disruptions among 12 therapists working with sexual violence survivors. While all therapists in the sample reported negative effects from working with traumatized clients, Steed and Downing (1998) noted that some participants were not able to differentiate the effects of trauma therapy from unresolved personal issues. Further highlighting the need for longitudinal research in this area, Steed and Downing (1998) noted that the most serious limitation in their study was some participants' inability to accurately recall their beliefs and levels of cognitive and emotional functioning prior to their emersion in clinical trauma work.

Premature Generalizations of the Construct

Vicarious trauma is increasingly being proposed to apply to a widening array of professionals outside the area of mental health. Pearlman and Saakvitne (1995a) state,

"Vicarious traumatisation can affect anyone who engages empathically with trauma survivors – journalists, police, emergency room personnel, shelter staff, prison guards, researchers, etc." (p.281). In addition to the expanding groups of professionals, the construct has recently been proposed to be applicable to professionals working with individuals who have experienced traumatic stressors outside the realm of interpersonal violence, such as life threatening illnesses (Clark & Gioro, 1998; Robinson, Clements & Land, 2003). Corresponding research, however, has not yet been conducted to determine the degree to which vicarious trauma may be generalized to these ever expanding groups of professionals and client populations (Sabin-Farrell & Turpin, 2003).

Research to date has been conducted almost exclusively with professionals working with clients who have experienced traumatic stressors resulting from interpersonal violence, such as sexual and domestic violence, and war related crimes (Brady, Guy, Poelstra, Fletcher Brokaw, 1999; Genest, Levine, Ramsden & Swanson, 1990; Kassam – Adams, 1995; McCann & Pearlman, 1990; Munroe, 1991; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). This focus appears quite appropriate in light of the three necessary conditions (exposure to traumatic and graphic material, exposure to the reality of human cruelty and participation in traumatic enactments) hypothesized to set the stage for vicarious trauma to occur (Pearlman & Saakvitne, 1995a). Exceedingly little empirical attention has been given to therapists working with traumatic stressors unrelated to violence who are unlikely to meet these proposed conditions within the context of therapy to determine if this generalization is indeed appropriate.

Conceptual Limitations

Researchers are only just beginning to comment on the conceptual limitations of vicarious trauma (Black & Weinrich, 2000; Sabin-Farrell & Turpin, 2003; Steed & Downing, 1998). Contrary to the assertion that vicarious trauma is a cumulative effect, Steed & Downing (1998) reported that within their sample, therapists did not perceive the negative effects of their work as increasing over time. In Chrestman's (1995) investigation of vicarious trauma in therapists, she reported "Many therapists reported episodes of extreme distress from which they recovered, but which were overwhelming to them for a short period of time" (p. 33). Other studies have suggested that therapists with more clinical experience show less cognitive disruptions and symptoms of traumatic stress than therapists new to the field (Chrestman, 1995; Gamble, Pearlman, Lucca & Allen, 1994; Pearlman & MacIan, 1995), which again, contradicts the notion that vicarious trauma is cumulative in nature. Vicarious trauma has in fact been suggested by some to be an acute versus a chronic state among therapists that may in fact dissipate over time (Chrestman, 1995; Steed & Downing, 1998). This possibility may provide some insight as to why research investigating vicarious trauma has been characterized by such inconsistency.

Among the quantitative studies that have been conducted on vicarious trauma, an interesting commonality has been a low level of overall symptomatology among participants (Arvay & Uhleman, 1996; Baird & Jenkins, 2003; Brady et al, 1999; Chrestman, 1995; Gamble, Pearlman, Lucca & Allen, 1994; Kadambi, 1998; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Rather than question the validity or existence of the phenomenon itself, researchers who have failed to find support for significant levels

of traumatic stress or vicarious trauma among their samples have tended to discount their own findings on the basis methodological limitations or on defensive posturing and underreporting of distress by subjects (Chrestman, 1995; Gamble, Pearlman, Lucca & Allen, 1994). As such, there appear to be discrepancies surrounding the intensity, high prevalence and severity of vicarious trauma described in qualitative studies (Steed & Downing, 1998; Wasco & Campbell, 2002) and the low level of symptomatology and cognitive disruptions assessed by quantitative researchers.

An often overlooked aspect of much of the research in the area of vicarious trauma is the fact that the majority of professionals providing trauma therapy appear to be coping well with the demands of their work (Brady et al, 1999; Ennis & Horne, 2003; Follette, Polusny & Milbeck, 1994; Goldenberg, 2002). As noted by several researchers, many professionals working in this area feel privileged, energized, and personally rewarded by the services they provide to traumatized clients (Black & Weinreich, 2000; Chrestman, 1994; Goldenberg, 2002; Steed & Downing, 1998). Vicarious trauma as it is currently conceptualized is limited in its ability to account for transformative aspects of providing trauma therapy that are positive and enriching for professionals (Chrestman, 1994; Sabin-Farrell & Turpin, 2003; Steed & Downing, 1998).

Recent Reviews

Just prior to the completion of this paper, Sabin-Farrell and Turpin (2003) published a critical and comprehensive review of published research and proposed theory behind the construct of vicarious trauma (April, 2003). This publication represents the first critical review to clearly and objectively address the multitude of concerns associated with the research on vicarious trauma, and question the constructs' validity. The ultimate

conclusion reached by these researchers is that "The evidence for vicarious trauma in trauma workers is inconsistent and ambiguous" (Sabin-Farrell & Turpin, 2003, p. 472). Their commentary on the state of knowledge and research on vicarious trauma highlights the methodological limitations, the inconsistency and disparity of research findings, and the lack of conceptual support for the construct, that are similar to those presented in this paper. Conclusions from the review of research in this paper appropriately echo those of Sabin-Farrell & Turpin (2003).

Summary

It appears that current thought and research surrounding vicarious trauma may be on the precipice of a debate that questions much of what has been accepted over the past decade. Evidence to support the notion that mental health professionals working with traumatized clients are significantly and adversely affected by their clinical work has been inconclusive at best, and unsupported at worst. Vicarious trauma has proven to be difficult to operationalize and measure, and support for the construct as a pervasive experience that is unique to trauma professionals has been inconsistent. Generalizing the construct to apply to other professionals across different types of traumatic stressors appears inappropriate in light of these research findings and extant measurement concerns. Allocating financial and human resources to address a problem whose prevalence and severity have not yet been clearly determined appears to be an even more untimely application of existing data.

The tasks of future researchers are clear. Vicarious trauma as it is currently conceptualized, needs to be empirically validated among trauma therapists. This should be undertaken using sound sampling techniques and research designs that include comparison

groups of mental health professionals representative of those working outside the area of trauma and whose exposure to trauma (either primary or secondary) is controlled. Comparisons might then be conducted to determine if the construct generalizes to other professional groups and/or other types of traumatic stressors unrelated to interpersonal violence. An essential task for researchers is to determine the validity of the TSI in accurately measuring and discriminating vicarious trauma from other phenomena with designs that use appropriate comparison groups and better control over confounding variables. Clarification is also needed to determine factors associated with vicarious trauma and how they may interact with one another to influence how therapists respond to clinical work.

Possibly the most consistent finding among research investigating the impact of providing psychological services is that the majority of professionals are not suffering emotional or psychological distress in response to clinical work and are coping well with the demands of their work in the face of workplace challenges and stressors specific to client populations (Coster & Schwebel, 1997; Elliot & Guy, 1993; Follette, Polusny & Milbeck, 1994; Thoreson, Miller & Krauskopf, 1989). Understanding aspects of wellness and resilience among professionals may serve to balance our current understanding of how professionals can be affected by clinical practice. Shifting empirical focus from mental health professionals' vulnerability to traumatic stress responses, onto their resiliency against it, could serve to identify significant protective or mitigating factors that have yet to be identified.

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CHAPTER 3

Vicarious Trauma and Burnout Among Therapists Working with Sexual Violence, Cancer and General Practice

Background

Providing psychological services can be rewarding and yet enormously challenging for helping professionals. Offering support and assistance to those coping with emotional pain, instability or crisis, can significantly tax the emotional energy and coping resources of professionals providing therapy (Farber & Heifetz, 1981, 1982; Maslach, 1982; Savicki & Cooley, 1987). Professionals working with trauma survivors, however, have been identified as being particularly at risk for being negatively affected by their work (Arvay & Uhlemann, 1996; Figley, 1995; Haley, 1974; Herman, 1992; Kassam-Adams, 1995; McCann & Pearlman, 1990; Neuman & Gamble, 1995; Schauben & Frazier, 1995).

There are presently many ways of conceptualizing how providing trauma therapy can impact the helping professional. Common consensus, however, on a descriptor that accurately conveys the uniqueness and range of responses to providing therapy, in addition to an explanation that accounts for how and why these professionals may be affected by their work, has not yet been reached. Counter-transference (McCann & Pearlman, 1995; Wilson & Lindy, 1994), burnout (Freudenberger 1974; Maslach, 1982), and compassion fatigue (Figley, 1995; Joinson, 1992) all offer ways for us to understand how professionals respond to their clinical work. Related to each of these constructs, yet thought to be distinct, is the phenomenon of vicarious trauma (McCann & Pearlman, 1990).

The term vicarious trauma was first used by McCann and Pearlman (1990) to describe the unique observed effects of providing psychotherapy to clients who had

experienced a violent traumatic stressor. The term describes the profound and permanent changes in how therapists think, feel and behave in relation to others and themselves as the result of their exposure to and empathic bonding with their clients' traumatic material (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Put simply, vicarious trauma refers to the process by which therapists themselves can become traumatized as a result of their emotional connection to the trauma of others (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Three conditions within the therapeutic dynamic largely specific to clinical work with trauma survivors have been theorized to facilitate this empathic bonding and produce the experience of vicarious trauma. These include: 1) empathic engagement and exposure of the therapist to graphic and traumatic material, 2) empathic engagement and exposure of the therapist to the reality of human cruelty and 3) the therapists' participation in traumatic re-enactments wherein client transference responses re-enact elements of the initial trauma within the therapy process (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

The experience of vicarious trauma is thought to be the result of a unique interaction between the therapist, their trauma work and their work setting. Although the experience varies across individuals, there are proposed commonalities to therapists' collective experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Vicarious trauma is thought to produce changes in the therapist's sense of spirituality, worldview, and self-identity as well as disruptions in cognitive schemas associated with trust, intimacy, safety, power, and control (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Subclinical symptoms of posttraumatic stress disorder (PTSD) also

hallmark the experience of vicarious trauma among professionals involved in trauma work (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

The concept of vicarious trauma clearly appears to resonate with professionals in the field of traumatology. It has been proposed to apply to expanding groups of professionals working outside the context of trauma therapy (Clark & Gioro, 1988; Goldenberg, 2002; Lowe, 2002; Pearlman & Saakvitne, 1995; Robinson, Clements & Land, 2003; Wasco & Campbell, 2002). Although the intuitive appeal of the construct has prompted several attempts at assessing and understanding the experience of vicarious trauma, research in this area to date has been plagued with lack of baseline data, disparate results and methodological limitations (Sabin-Farrell & Turpin, 2003).

Studies investigating vicarious trauma among professionals have focused almost exclusively on professionals working with populations who have experienced a traumatic stressor associated with interpersonal violence (Brady, Guy, Poelstra, & Fletcher Brokaw, 1999; Genest, Levine, Ramsden & Swanson, 1990; Kassam – Adams, 1995; McCann & Pearlman, 1990; Munroe, 1991; Schauben & Frazier 1995; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995). No studies have been conducted to investigate the applicability of the construct as it may apply to professionals working with traumatic stressors unrelated to interpersonal violence (e.g. life threatening illness) in situations unlikely to result in the three therapeutic conditions theorized to produce vicarious trauma. More crucially, no studies have been conducted using appropriate comparison groups to determine if trauma therapists indeed exhibit significantly greater levels of vicarious trauma and traumatic stress than do their counterparts working primarily outside the area of trauma. Reports of trauma therapists' levels of stress and distress have been

largely descriptive and anecdotal (Sabin-Farrell & Turpin, 2003; Sexton, 1999). Quantitative investigations have yielded limited and inconsistent support for the findings reported in qualitative investigations (Sabin-Farrell & Turpin, 2003). As such, the prevalence and degree of stress/distress associated with vicarious trauma among these professionals has not been clearly substantiated by commonly used assessment tools.

The Traumatic Stress Institute Belief Scale (Revision M; Pearlman, 1996) was developed to assess the cognitive disruptions in psychological need areas sensitive to trauma that is indicative of vicarious traumatisation. Although the measure represents an improvement over studies using descriptive reports or reliance on non-standardized questionnaires to assess trauma related distress, the TSI appears to rely on flawed normative data. Current normative data on mental health professionals reported by Pearlman (1996) was collected from professionals attending trauma-training workshops. It remains unclear as to how their trauma histories (whether personal or professional) and trauma exposure were controlled for, resulting in the possibility of inflated TSI scores for this group. As the measure has not been administered to professionals working across a variety of practice settings, the measure appears to have no solid baseline data to which subsequent scores can be compared.

The ability of the TSI to accurately assess vicarious trauma and differentiate the phenomenon from other constructs presents a significant issue for researchers. Conceptually considered distinct, some researchers have found support for the contention that burnout and vicarious trauma are separate, yet related experiences (Schauben & Frazier, 1995; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995). The results from other studies however suggest that the two constructs have not clearly been distinguished

on both conceptual and psychometric levels (Adams, Matto & Harrington, 2001; Kadambi, 1998). Jenkins and Baird (2002) recently attempted to address this issue with an investigation of the concurrent, discriminant and construct validity of several assessment tools assessing vicarious trauma, compassion fatigue and burnout. Their findings supported the convergent and divergent validity of the TSI and reported good discriminant validity from measures of burnout. Findings from other researchers however, have not supported these results (Adams, Matto & Harrington, 2001; Kadambi, 1998).

Purpose of the Study

Close examination of the extant research on vicarious traumatisation indicates that further investigation is necessary to determine the validity of the construct and the TSI in measuring the phenomenon. The purpose of this research was to investigate vicarious trauma and burnout among professionals providing services primarily to clients who had experienced different types of traumatic stressors in contrast to an appropriate comparison group. In identifying and distinguishing between participants hypothesized to be highly vulnerable to vicarious trauma compared to participants not identified as high risk, the divergent validity of the TSI was also investigated. Finally, the relationship between vicarious trauma and burnout among participants was to be explored and clarified.

Three groups of mental health professionals providing counselling to three different client populations were surveyed to assess and compare levels of vicarious trauma, traumatic stress symptoms, burnout and their spiritual well-being. The TSI Belief Scale, Revision M, the Impact of Event Scale, the Maslach Burnout Inventory Human Services Survey and the Spiritual Well Being Scale were used to respectively assess these dimensions among participants. Two groups of participants provided counselling

primarily to client populations who had experienced a traumatic stressor associated with either sexual violence or a cancer diagnosis. A third participant group working primarily with a range of clients and presenting issues was included for comparison purposes.

It was hypothesized that there would be significant differences between groups on measures of trauma related distress and spirituality when confounding variables were controlled (e.g. personal trauma history). Specifically, it was predicted that due to the presence of vicarious trauma, participants working with trauma clients would exhibit significantly higher levels of traumatic stress compared to participants working with a variety of client issues. These differences were also predicted to hold true if the effects of burnout were controlled. Consequently, the distinctiveness of the constructs and the divergent validity of the TSI Belief Scale would be assessed. Previously identified variables predictive of traumatic stress were then explored.

Method

Participants

Three groups of mental health professionals providing counselling to different primary client populations were surveyed. Qualitative information was also gathered to further understand participants' experience of their work with respective client populations regarding traumatizing aspects of therapy, successful coping, and continued motivation to provide psychological services. Two of these participant groups worked primarily (over 50% of their clinical case load) with client populations who experienced a "traumatic stressor". A traumatic stressor was defined as a situation in which the person "experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others"

(DSM – IV; American Psychological Association, 1994, pp. 427). A final participant group of professionals who provided services primarily (over 50% of their clinical case load) to a range of clients/issues and who were not working primarily with clients who experienced traumatic stressors, served as a comparison group.

In order to control for potentially confounding variables, screening criteria were set to determine appropriate participants. Participants were limited to those who indicated providing counselling primarily to one of the three client populations of interest. Participants were asked to rank the percentage of their clinical time spent with their primary client population. Only participants who indicated they spent more than 50% of their counselling time providing services to one of the three primary client populations were included in the final sample. The majority of participants, 68.2%, indicated that they spent between 75% and 100% of their clinical time working with their primary client population. The remaining 31.8% of the sample indicated they spent between 50% and 75% of their clinical time working with their client population. Participants that indicated they worked with two or more of the primary client populations either presently or in the past year were also excluded from the final sample.

Overall, 625 participants across three groups were surveyed. Completed surveys totaled 251, resulting in a response rate of 40%. This response rate is consistent with previous research involving mental health professionals (Kassam – Adams, 1995; Pope & Feldman-Summers, 1992). From the returned surveys across groups, 30 surveys did not meet screening criteria and were excluded from the sample. A final sample size of 221 participants was reached with 86 participants in group one, 64 in group two and 71 in group three.

It is important to note that significant world events occurred while this study was being conducted. Mid-way through the data collection, the United States of America was attacked by terrorists on September 11, 2001. The terrorist attacks resulted in widespread media coverage of the actual attacks, subsequent damage and clean up efforts. Via the media, people around the world were secondarily exposed to the trauma of these events, the stories/images of individuals who were killed in the attacks and those of their family members.

In an attempt to minimize the impact these events may have had on participants' responses to survey measures, data collection was halted for a period of 6 months. To further assess the potential impact of the terrorist attacks, two additional questions were added to the end of survey measures. These questions inquired about participants' perceived personal impact of September 11th and asked whether they would have responded differently to survey measures prior to the event. Of the 113 participants who were surveyed and responded after September 11th, 56%, indicated that they were minimally impacted by these events. The remaining 44% indicated they were moderately to profoundly affected by the terrorist attacks. Of these participants, however, only 6% indicated they would have responded differently to survey measures prior to September 11, 2001.

Group One: Sexual Violence: Participants within group one consisted of professionals providing counselling primarily to individuals who experienced the trauma of sexual violence. This professional group has been consistently identified by previous researchers as exhibiting signs of vicarious trauma, and meet the three hypothesized criteria for the therapeutic conditions within which vicarious trauma can occur (Herman,

1992; Munroe, 1991; Neumann & Gamble, 1995; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). A total of 260 professionals providing counselling within 44 Canadian Sexual Assault Centers were surveyed. One hundred and two surveys were completed and returned, for a response rate of 39%. Sixteen surveys that were returned by this group were excluded on the basis of screening criteria and/or incomplete data. The final sample size for this group was 86 participants.

Group Two: Psycho-oncology: Participants comprising group two were professionals providing counselling primarily to individuals affected by cancer. This professional group was selected because while their primary client population experienced a traumatic stressor, they were unlikely to encounter the therapeutic conditions proposed to produce vicarious trauma (e.g. exposure to stories of human cruelty) in the context of providing therapy.

A total of 183 professionals providing counselling to cancer patients and their families within Canadian hospitals and cancer centers across eight provinces were surveyed. Sixty-seven surveys were returned, resulting in a response rate of 37%. Eight surveys were excluded on the basis of screening criteria and/or missing data. This resulted in a shortage of participants required for planned statistical analyses. Five additional surveys were obtained from professionals providing counselling services to cancer patients and their families from two facilities in the United States of America. Ultimately, the final sample size for this group was 64 participants.

Group Three: General Practice: Participants in group three were chosen to represent a comparison group of professionals providing counselling to clients with a wide range of issues, reflective of "typical" mental health professionals working outside the area

of trauma. Researchers have reported that university counselling centers see and treat a wide range of client problems (Benton, Robertson, Tseng, Newton & Benton, 2003; Heppner, Kivlighan, Good, Roehlke, Hills & Asjby, 1994; Pledge, Lapan, Heppner, Kivlighan & Roehlke, 1998). A total of 182 participants from 23 Canadian university counselling centers within 8 provinces were surveyed. Eighty-two surveys were returned, resulting in a response rate of 45%. After excluding participants that did not meet screening criteria and/or surveys with missing survey data, 71 surveys were included in the study.

Procedure

Potential participants were mailed survey packages containing a letter explaining the purpose of the intended research (see Appendix A) and instructions as to how to complete the enclosed Participant Questionnaire and four dependent measures. Survey recipients were instructed that should they consent to participate in this study, they need simply complete the survey materials and return them to the researcher in the self – addressed stamped envelope provided. Due to the sensitive nature of the questions on survey measures and to ensure confidentiality, participants completed and returned the survey anonymously. Sampling from each professional group continued until a minimum of 60 usable surveys were obtained in each group.

Measures

The Participant Questionnaire is a 23 item questionnaire developed by the researcher to collect demographic information and to assess aspects of work specific to primary client populations (see Appendix B). Information that was collected by this measure also served to identify participants who did not meet criteria for inclusion in the

final sample (e.g. not enough clinical time with primary populations). The Participant Questionnaire collected information similar to other researchers investigating vicarious trauma (Brady, Guy, Poelstra & Fletcher Brokaw, 1999; Pearlman & MacIan, 1995; Schauben & Frazier, 1995) in order to examine the impact of these variables on traumatic stress responses among participants. Questions on this measure included; the participants' length of time in the field, exposure to traumatic material, work setting, supervision arrangements, education, presence of a personal trauma history, and whether they addressed the effects of their work in personal therapy.

Supplemental information, regarding venues to address personal impact of work, specialized training, previous trauma work, and perceived exposure to descriptions of human cruelty were assessed to determine predictive or mitigating influences on dependent measures. The Participant Questionnaire also contained three open - ended questions to collect qualitative information about how participants experienced their work. Participants were asked to identify aspects of their work they felt were traumatizing, how they coped with the effects of their work and what motivated them to continue to provide services to their primary client population.

The Traumatic Stress Institute Belief Scale - Revision M (TSI; Pearlman, 1996) is a 77 item questionnaire which measures cognitive disruptions in five psychological need areas (relative to self and others) hypothesized to be sensitive to trauma (safety, trust, intimacy, esteem and power) producing 10 subscale scores (see Appendix C). The overall reported reliability (Cronbach's alpha) of the TSI is .98 (Pearlman, 1996). Subscale reliabilities range from .77 (Other Safety, Self Control) to .91 (Self-Esteem) (Pearlman, 1996).

The TSI also yields a total score, which represents the overall extent of cognitive disruption. Higher scores represent greater levels of disturbance. The TSI was used to determine the overall level of cognitive disruption suggestive of vicarious traumatisation for participants in each of the three groups.

The Impact of Event Scale (IES; Horowitz, Wilner & Alvarez, 1980) is a 15 item self report measure that has been used to assess reactions to stressful events with diverse populations. Containing two subscales - Intrusion and Avoidance - the IES assesses the central features of Posttraumatic Stress Disorder. Reliability data indicates good internal consistency, with coefficients of .86 for the Intrusion subscale and .90 for the Avoidance subscale (Fischer & Corcoran, 1994). Participants in this study were directed to indicate how frequently (on a four point scale) each of the 15 statements were true for them concerning their work with their primary client population (see Appendix D). The IES was used to identify trauma related distress among participants.

The Maslach Burnout Inventory - Human Services Survey (MBI; Maslach, Jackson, & Leiter, 1996) is a 22 item questionnaire designed to assess the three central aspects of burnout: Emotional exhaustion, depersonalization and decreased sense of personal accomplishment (see Appendix E). The MBI has been used extensively with mental health professionals with reported reliability coefficients (Cronbach's alpha) of .90 for the Emotional Exhaustion subscale, .79 for Depersonalization and .71 for Personal Accomplishment (Maslach, Jackson & Leiter, 1996). The measure produces three scores for each of the three aspects of burnout which are not combined, but can be categorized into high moderate or low levels, relative to normative sample data (Maslach, Jackson & Leiter, 1996).

The Spiritual Well Being Scale (SWBS; Ellison & Smith, 1991) is a 20 item questionnaire that assesses the quality of one's spiritual well being as it relates to a relationship with god and sense of purpose and meaning in life. The measure yields two subscale scores, Religious Well Being and Existential Well Being, as well as an overall score (see Appendix F). Spirituality has been identified as a key area that can be adversely affected by vicarious trauma (Pearlman & Saakvitne, 1995). As such, the measure was included to determine if groups differed on levels of spiritual well being which, could also suggest the presence of vicarious trauma.

Results

Participant Demographics

The final sample consisted of 221 participants: 186 women and 35 men. The mean age of participants was 42 years, ranging from 21 to 63 years of age. Participants spent an average of 11.49 (SD = 7.90) years engaged in the practice of counselling, ranging from 1 to 38 years in the field. The majority of participants, 67.9%, had obtained a graduate degree. Among the remainder of participants, 25.3% reported obtaining an undergraduate degree and 6.8% reported a diploma or certificate.

The amount of time participants had been working with their primary population ranged from 1 to 31 years, averaging 8.26 (SD=6.72) years. The majority of participants, 52.1%, reported receiving clinical supervision from an appropriate professional. Of those receiving supervision, 16.07% indicated only treatment issues were addressed and 79.46% reported supervision addressed both treatment issues and the personal impact of their work. Supervision addressed issues other than treatment or personal impact of clinical work for the remaining 4.47% of participants. Only a small proportion, 10.5% of the

sample indicated that they had no venue at all to address the personal impact of their work.

A large proportion of participants, 58.2%, indicated that they had personally experienced a traumatic stressor as defined by the DSM-IV (American Psychological Association, 1994). Of those indicating a personal trauma history, 36% indicated experiencing more than one traumatic stressor. While these percentages may seem high, it has been recently estimated that the lifetime prevalence of experiencing a traumatic stressor as defined by the DSM-IV, is close to 90% (Breslau & Kessler, 2001). In addition, other researchers investigating vicarious trauma among therapists have found highly similar rates (60%) of participants reporting a trauma history in their overall sample (Pearlman & MacIan, 1995). Demographic information for groups one, two and three are presented in Tables 3-1, 3-2, and 3-3 respectively.

Performance on Dependent Measures

In order to examine how participants in this sample compared to those in previous research and normative data on various measures, descriptive statistics for each dependent variable were calculated. Mean and subscale scores for the three groups on each dependent measure are presented in Table 3-4. Participants' mean scores, and standard deviations were comparable to previous researchers' findings for groups of mental health professionals for the TSI (Pearlman, 1996), MBI (Maslach, Jackson & Leiter, 1996) and reported normative data for the IES (Fischer & Corcoran, 1994).

Across groups, participants obtained a mean score of 141.27 (SD = 26.27) on the TSI with scores ranging from 91 to 227. Participant scores on the IES averaged 7.65 (SD = 6.54) for the Intrusion subscale, 7.59 (SD = 7.48) for the Avoidance subscale and 15.22

(SD = 13.08) for the IES total score. Scores above 26 on the IES are considered to be indicative of moderate to severe levels of traumatic stress (Horowitz, Wilner & Alvarez, 1980). Of the entire sample, 20.8% scored at or above this score. Within individual groups 21.67% from group one, 23.46% from group two and 20.34% from group three obtained scores at or above 26, suggesting moderate to severe traumatic stress symptoms.

The MBI yields three subscale scores. Across groups, participants obtained a mean score of 19.27 (SD= 9.48) for Emotional Exhaustion, 4.27 (SD= 4.03) for Depersonalization and 41.38 (SD= 4.03) for the Personal Accomplishment subscales. Scores for each of these subscales can be classified into low, moderate and high categories based on normative samples of mental health professionals (Maslach, Jackson & Leiter, 1996). Participants' mean scores in this sample fell within the moderate range for Emotional Exhaustion and the low range for both Depersonalization and Personal Accomplishment.

For the Emotional Exhaustion subscale, 42.08% of the entire sample fell within the low range, 37.10% in the moderate range and 20.81% in the high range. On the Depersonalization subscale, 76.4% were within the low range, 18.6% were moderate and 5.0% fell within the high range. Within the Personal Accomplishment subscale, the majority of participants, 75.3% scored within the high range, 22.8% participants scored within the moderate range and only 1.8% fell within the low range. High scores on both Emotional Exhaustion and the Depersonalization scale are considered to be the hallmarks of professional burnout (Maslach, Jackson & Leiter, 1996). Only 2.3% of the entire sample obtained high scores on both of these subscales. The three participant group

means corresponded with mean scores in the moderate range for Emotional Exhaustion, low range for Depersonalization and high range for Personal Accomplishment.

Scores for the SWB appeared to be affected by participant attitudes regarding the questions within the scale. Several participants indicated that they felt the language used by the SWB did not accurately assess their experience. Numerous comments were written on the measure and indicated many participants had more "spiritual" and not necessarily religious beliefs about "God" or a "God". Participant comments also indicated that some were offended by either being asked about their religious beliefs in way that presumed a connection with "God" or a "God". Therefore, some participants chose to either omit questions surrounding their relationship with "God" or refrained from completing the measure entirely. Consequently, only 82% of the final sample had three complete scores on the measure. Of those participants who completed the measure, mean scores for the total score, Religious Well Being, and Existential Well Being were 91.58 (SD= 17.45), 40.96 (SD= 14.69) and 50.86 (SD = 6.69) respectively. Higher scores represent greater states of well being. In light of the concerns surrounding the reliability and validity of this measure with this sample, only the Existential Well Being subscale was included as a dependent measure for further analyses.

Reliability and Validity of the TSI

To determine the reliability of the TSI Revision M in this sample, reliability data was determined using Cronbach's Alpha. Internal consistency was found to be high, at .92. To investigate the divergent and convergent validity of the TSI Revision M, the Pearson Product Moment Correlation was used to explore relationships among dependent measures. It was predicted that the TSI Revision M would have high positive correlations

with the IES total score and the two subscales, as both measures purport to assess aspects of traumatic stress responses. As the TSI has been designed to assess aspects of vicarious trauma, correlations with the three subscales of the MBI were hypothesized to be positive, but weaker than the correlations with the IES. Correlational analyses are presented in Table 3-5.

Contrary to expectations, the TSI Revision M showed stronger correlations with each of the three subscales of the MBI in comparison to the IES total and subscale scores. The strongest positive correlation was between the TSI total score and the Emotional Exhaustion subscale, followed by the Depersonalization and Personal Accomplishment subscales respectively. The TSI total score and the Existential Well Being subscale of the SWB showed the strongest relationship among dependent variables, with a strong negative correlation.

Examining Differences Between Groups

To test the hypotheses that there would be significant differences between groups on the TSI and IES, a Multiple Analysis of Variance (MANOVA) was used. It was predicted that due to the presence of vicarious trauma, group one (sexual violence) would exhibit significantly higher scores on the TSI and IES than group three (general practice). If vicarious trauma was present within group two (psycho-oncology) they would similarly exhibit higher scores on the TSI and IES than group three. Differences between groups on remaining dependent measures and the MBI were also explored to determine if the effect of burnout needed to be controlled for between groups and to generate ideas for future research.

A Multiple Analysis of Covariance (MANCOVA) was initially planned to determine differences among participant groups on the dependent measures with participant trauma history as a covariate. Unexpectedly, exploratory correlations suggested that participant trauma history was not significantly related to scores on the dependent measures. Consequently, a 3 X 7 (group by dependent measure) MANOVA was the most appropriate analysis to assess differences between groups. An alpha level of .05 was used for all analyses given the exploratory nature of the study. Groups were not found to differ significantly on any of the dependent measures. (F (14, 358) = .974, p> .05).

Exploring the Impact of Trauma History

As the research investigating the importance of therapists' personal trauma history in traumatic stress responses resulting from clinical work has been so inconsistent, the differential impact of trauma history was explored. Differences on dependent measures between participants who indicated they had experienced a traumatic stressor (n= 124) and those who did not have a personal trauma history (n=89) were investigated using a 2 X 7 (trauma history by dependent measure) MANOVA. No significant differences were found (F (7, 179) = 1.127, p> .05).

Investigating Proportional Differences

Although no significant differences in traumatic stress, vicarious trauma or burnout were found between the three groups, there were participants within each group reporting high levels of trauma related distress as measured by the TSI and IES. Chi square post-hoc analyses were therefore conducted to explore the possibility of proportional differences between groups for individuals showing high levels of trauma related distress. It was expected that participants working with trauma clients (groups 1 and 2) would have

a significantly higher proportion of participants with higher levels of trauma related distress in comparison to participants working with a variety of client issues (group 3).

Scores above 26 on the IES suggest moderate to severe traumatic stress (Horowitz, Wilner & Alvarez, 1980). To determine if the three groups differed in the proportion of participants exhibiting traumatic stress symptoms, two categorizes based on IES total score were created: Low = scores under 25, and high = scores at or above 26. A 3 X 2 (group by IES category) Pearson Chi Square analysis was conducted. There were no significant differences in the proportion of participants in each category of traumatic stress symptoms across primary client populations ($X^2 = 1.031$, df = 2, $p > .05$).

Participant scores on the TSI were also divided into three categories to explore proportional differences between participant groups. TSI scores that fell one standard deviation below the sample mean were classified as low (at or below 115). Scores falling one standard deviation above the mean were classified as high (at or above 168). Remaining scores were classified as average. Across groups, 19.6% fell within the low range, 64% within the average range and 16.4% obtained high TSI scores. A 3 X 3 (group by TSI score category) Pearson Chi Square analysis was conducted. Analyses revealed no significant differences between proportions of participants between groups on TSI score categories ($X^2 = 1.532$, df = 4, $p > .05$).

Given the exploratory nature of this study and to ensure that possible differences between groups were identified, the proportion of participants in category ranges of the subscales of the MBI for each group were also compared. Again, a 3 X 3 (group by MBI subscale category) Chi Square was used to determine proportional differences in levels of Emotional Exhaustion, Depersonalization and Personal Accomplishment. Consistent with

the results of earlier analyses, no significant differences were found between groups for levels of Emotional Exhaustion ($X^+ = 1.604$, df = 4 $p>.05$) or Personal Accomplishment ($X^+ = .472$, df = 4, $p>.05$).

A significant difference was found, however, between the proportions of participants in groups among the three categories on the Depersonalization subscale ($X^+ = 11.089$, df = 4 , $p<.05$). The proportions of participants across groups in each of the three categories are presented in Table 3-6. Group one (sexual violence) had the highest proportion of participants falling in the low range (87.5%) in comparison to groups two (68.2%: psycho-oncology) and three (76.1%: general practice). Within the moderate range of the Depersonalization subscale, group two had the highest proportion of participants (28.2%) compared to group one (7.8%) and three (16.9%). Interestingly, group three had the highest proportion of participants (7.0%) scoring within the high range on this subscale compared to group one (4.7%) and two (3.5%).

The lack of significant differences between groups on dependent measures and levels of trauma related distress and burnout were quite unexpected. Although objective measures yielded little significance, participants were asked about their perceptions of the nature of their work. A final chi square analysis was conducted to determine if there were differences between groups on their perceptions of whether or not they perceived their clinical work to be potentially traumatizing. Significant differences were found between groups ($X2 = 38.476$, df=2, $p <.05$). The majority of participants working with sexual violence (83%) felt their work was potentially traumatizing compared to with the proportions of participants working with cancer (50%) and general practice (36%) who felt their work was potentially traumatizing.

Identifying Predictive Variables

A stepwise multiple regression analysis was used to test the predictive power of variables theorized to contribute to vicarious trauma. Six variables, which included supervision, level of exposure to human cruelty, venue to address concerns, number of years in the field, education level and personal trauma history were included in the regression analyses. Two variables, length of time in the field and personal trauma history were found to contribute to TSI scores (F (1, 205) = 4.757, p<.05). While results were statistically significant, the total proportion of variance accounted for by both variables (R^2 = .056) was minimal.

The same six variables were used in a step-wise multiple regression to determine if they were predictive of traumatic stress as measured by the IES given the validity concerns surrounding the TSI in measuring vicarious trauma. Results indicated that only one variable, length of time in the field contributed to IES scores (F (1, 208) = 4.567, p<.05). Again, the variance within IES scores accounted for was minimal (R^+ = .022).

Regression analyses using the same variables as predictors were also conducted for participant scores on the Emotional Exhaustion subscale of the MBI. This analysis was conducted as the Emotional Exhaustion subscale was found to have the highest correlation of all MBI subscales with the TSI. Additionally, as vicarious trauma and burnout appear to have a significant degree of overlap it was felt that exploring predictive variables on this measure may assist in providing important additional information into predicting professional distress. One variable, whether participants had a venue to discuss the impact of their work was found to contribute to Emotional Exhaustion scores (F (1, 216) = 10.685, p<.05). Approximately 5% of the variance within this subscale was associated

with this variable ($R^+ = .047$). There was a negative relationship between emotional exhaustion and having a venue to address the impact of clinical work.

Examining High TSI Scores

To generate ideas for future research a closer look was taken at the 35 participants in the sample (16.4% of the sample) who attained a high TSI score (total score at or above 168). Demographic information for this subset of the sample is presented in Table 3-7. Descriptive statistics across dependent measures are displayed in Table 3-8. While the size of this sample subset limited statistical investigations, correlations among the dependent variables for this group were explored. Results are presented in Table 3-9. The correlational patterns between dependent measures for this high TSI group appeared to be slightly different than those from the entire sample. For example, the Emotional Exhaustion subscale of the MBI showed the greatest relationship with the TSI, with a strong positive correlation. Unlike the entire sample correlations, this subgroup showed a moderate negative correlation between the TSI and the Existential Well Being subscale of the SWB scale. Surprisingly, in comparison to the moderate negative relationship between the TSI and Personal Accomplishment subscale of the MBI in overall sample correlations, almost no relationship was also found between these variables in the high TSI subgroup.

Discussion

Unexpectedly, the results of this study did not show statistically significant results, which, in itself, may be very important. The clear finding from this study was that there was very little difference among professionals providing counselling to different client populations in their assessed levels of vicarious trauma, traumatic stress symptoms and

levels of burnout. Consequently, many of analyses planned to differentiate vicarious trauma from burnout were not carried out.

As with previous research, the concern that a response bias may have affected results (e.g., professionals doing well emotionally may have been more likely to respond to the survey) also applies to this sample. The lack of significant findings could also be attributable to a self selection bias. Therapists working with these client populations self-select into these groups and it is likely they would do so and remain partially on the basis of their ability to tolerate the emotional demands of clinical practice with their particular client population. Indeed, it is important to note that the sample size in this study was small and when comparing groups there is always a risk of extraneous variables not being adequately controlled. Regardless of these standard caveats, the results from this investigation spark a number of critical thoughts surrounding the construct of vicarious trauma, how it is conceptualized and measured.

Psychometric Difficulties with the TSI

Results from this study contribute to previous research suggestive of psychometric limitations of the TSI (Adams, Matto & Harrington, 2001; Kadambi, 1998). The most recent revision of the measure (Revision M) failed to discriminate between samples of professionals who have been hypothesized to be likely to experience cognitive disruptions consistent with vicarious trauma. In addition, this version of the TSI continues to show stronger correlations with established measures of burnout than with measures of traumatic stress. This degree of overlap suggests that the TSI may not be assessing vicarious trauma but aspects of burnout. Again, these relationships call into question the conceptual distinctiveness of vicarious trauma.

The TSI is increasingly being shown to be limited in terms of assessing the phenomena of vicarious trauma. At the very least, the TSI should be used in conjunction with other more established measures of traumatic stress to assess vicarious trauma. Accurately assessing vicarious trauma may best be achieved by including measures that go beyond the cognitive and behavioral components of the phenomenon and assess the affective and physiological components of the experience.

Conceptual Challenges

There may be an alternative to psychometric problems accounting for the lack of divergent validity found in this study. The possibility that there was no phenomenon that was distinct to participant groups to begin with, remains. The findings of this study beg the question of whether the TSI is accurately assessing the present phenomenon of vicarious trauma or if the phenomenon of vicarious trauma is indeed present.

The theoretical assumptions that underlie the development of vicarious trauma clearly suggest that professionals who are exposed to traumatic stressors via clients who have been violently victimized are at a particularly high risk of being traumatized themselves (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The results of this study do suggest that more therapists working with traumatic stressors that involve interpersonal violence perceive their clinical work as "potentially traumatizing" than therapists working with traumatic stressors not involving interpersonal violence or those working with a variety of client issues. This finding could indicate that the TSI as an assessment tool lacks the sensitivity to detect difference and/or is not comprehensive enough to accurately assess the overall experience of vicarious trauma. Alternatively,

there could be differences between professionals' perceptions of the impact of trauma work and their measurable levels of distress.

The absence of differences between the degree of measured distress between those who work with clients that have experienced different types of traumatic stressors challenges the notion that there is something specific about trauma therapy that produces a unique constellation of objective symptoms and experiences for the clinician. Although the experience of vicarious trauma may be a legitimate phenomenon for some, it may occur at similar rates among professionals providing counselling across client populations.

While the sensitivity of the measures used in detecting differences between participant groups in this study are in question, the presenting symptoms and cognitive disruptions associated with vicarious trauma could also fluctuate over time. Some researchers have found that professionals new to the practice of therapy with trauma clients show significantly higher levels of cognitive disruptions and traumatic stress symptoms as compared to colleagues who have been in the field for an extended period of time (Gamble, Pearlman, Lucca & Allen, 1994; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). No studies, however, have compared these new professionals' levels of traumatic stress to their peers working outside the area of interpersonal trauma to determine if the levels of traumatic stress are unique to only those working in the area of trauma. Indeed, elevated levels of stress and traumatic stress may be a universal experience to new professionals adjusting to the emotional and professional challenges of providing counselling regardless of their client populations. In sum, vicarious trauma as it is currently conceptualized may be more of an acute state rather than a chronic condition among a variety of counselling professionals (Chrestman, 1995; Steed & Downing, 1998).

In light of the current findings, it would appear that a re-conceptualization of the phenomenon of vicarious trauma may warrant consideration. Specifically, the validity of the assumption that the professionals' exposure to clients' traumatic material and tales of human cruelty may represent the "active ingredients" in the development of traumatic stress reactions should be examined further. Instead, factors related to the manner in which the therapist empathetically connects or identifies with client material, and the subsequent processing of their own feelings around it, may be more important in the development of traumatic stress than the content or dynamics of the therapy being provided.

If we consider the research that has attempted to identify variables predictive of traumatic stress and vicarious trauma, it becomes evident that the variables that have been subjected to investigation (with the exception of personal trauma history) have been largely external and situational in nature (e.g., work setting, size of caseload, education level). Collectively, these studies have produced inconsistent results surrounding the predictive power of variables hypothesized to produce vicarious trauma (Sabin-Ferrell & Turpin, 2003). Moreover, when significant findings have been reported, the amount of variance accounted for by these variables has been minimal (Sabin-Ferrell & Turpin, 2003).

In considering the contributions and interactions between factors that influence whether mental health professionals will experience traumatic stress reactions, individual and interpersonal characteristics of the clinician may be the most important determinant of how he/she will impacted by the provision of counselling. Perhaps it is because vicarious trauma has been viewed as "normal and inevitable" (McCann & Pearlman, 1990; Pearlman

& Saakvitne, 1995) that comparatively little attention has been devoted the examination of therapist characteristics (with the exception of personal trauma history) that may predict the development of traumatic stress in response to clinical work. Parallel research investigating the experience of traumatic stress among individuals directly exposed to catastrophic events has demonstrated that the majority of people exposed to a traumatic stressor do not exhibit persistent, debilitating traumatic stress reactions (Breslau, 2002). Furthermore, research investigating factors that contribute to the development of post traumatic stress disorder following a direct traumatic stressor supports the notion that pre-morbid functioning, personal characteristics and peritraumatic psychological processes play a more salient roles in determining clinical symptoms than the characteristics of the traumatic stressor itself (Katz, Pellegrino, Pandya, Ng & DeLisi, 2002; Lauterbach & Scott, 2001; Ozer, Best, Lipsey & Weiss, 2003). Correspondingly, it would seem counter-intuitive to expect to find differing trends among therapist populations who are exposed to second-hand accounts of traumatic experiences through their clients.

The Distressed Subset

Regardless of the theoretical concerns that have been raised about the experience of vicarious trauma, there was a very small subset of the sample in this study that did report elevated levels of traumatic stress as measured by the TSI and IES. What is notable about this subset is not only that their distress was unrelated to their primary client population, but also their proportion in relation to professionals not reporting significant levels of traumatic stress. Of the 221 participants, only 5% of the sample (n=12) showed elevated levels of trauma related distress with high TSI and high IES scores. Several studies investigating aspects of professional distress and wellness across client populations

have concluded that the majority of mental health professionals are not suffering significant emotional or psychological concerns, and in fact are coping well with the demands of their work (Coster & Schwebel, 1997; Elliot & Guy, 1993; Raquepaw & Miller, 1989; Thoreson, Miller & Krauskopf, 1989). There is likely to always be a marginal group of professionals, however, consistently across client populations, work settings and workloads, that are affected greatly by their clinical work.

Of the 16.4% of the sample that attained high TSI scores, 23% reported that they did not feel their work was traumatizing to them despite their elevated TSI scores. It could be that some therapists experiencing these levels of cognitive disruption may not subjectively experience a sense of distress (desensitization) or could lack awareness that may stem from their level of distress. However, the possibility exists that these professionals were experiencing these cognitive disturbances from events outside of their work life.

The Value of Vicarious Trauma as a Construct

Although there are clear psychometric and conceptual questions surrounding the phenomenon of vicarious trauma, there does appear to be something intuitively resonant with many clinicians. In addition, the construct does attempt to offer an explanation as to how and why mental health professionals can be deeply affected by providing counselling. For a minority of professionals, the idea of significant permanent change in internal and external functioning may be very relevant. For these professionals, vicarious trauma offers a framework for understanding their experience in a way that serves to respect and normalize their response to their work.

The emphasis the construct places on the unique interaction between the professional, their work and their work setting in determining how the professional can be affected does account for the range of responses professionals may exhibit in response to clinical practice. While accounting for individual differences is important, common aspects of the experience of these professionals need to be clearly identified and defined if pragmatic interventions are to be developed. Increasingly, contemporary researchers are falling short of accomplishing this task in accurately identifying work related risk factors or individual professionals at risk for vicarious trauma to assist in planning prevention or early intervention strategies (Sabin-Farrell & Turpin, 2003).

Perhaps the most valuable idea surrounding the construct of vicarious trauma is the centrality of the notion that empathic connection to traumatic material as the mechanism by which trauma is transmitted from the client to the therapist. Empathic connection may in fact be one of the most important determinants in professionals' subjective experience and measurable level of distress in response to clinical practice. What appears to be unresolved is whether or not the client's traumatic material is the catalyst in producing traumatic stress among mental health professionals.

The role of empathy in the development of vicarious trauma and traumatic stress among professionals has only very recently begun to receive empirical attention. Recent unpublished studies have found significant relationships between empathy styles, cognitive disruptions associated with vicarious trauma, and symptoms of traumatic stress among professionals working with traumatized clients (Marmaras, 2001; Moosman, 2002; Wertz, 2001). The results from these initial studies, although limited to professionals working with trauma survivors, show promise in contributing to our understanding of how and why

some professionals may experience traumatic stress reactions from clinical work. Further research in this area needs to be conducted with professionals working with a variety of client populations to again assess if this finding is unique to trauma therapists.

Figley (1995) has also suggested that it is in fact the professionals who are the most empathic who are at greatest risk to experience negative emotional and psychological effects from their work. He argues that professionals who have the greatest capacity to empathize are the most vulnerable to experiencing "emotional contagion" (Miller, Stiff and Ellis, 1988) wherein therapists exhibit similar affective responses to their clients' presenting or anticipated emotions. It would certainly be interesting to determine if professionals who possess the greatest empathic ability are also those most likely to report distress in response to clinical work. Another area of future research may be to examine the relationship between therapeutic efficacy and the development of traumatic stress symptomatology in mental health professionals.

Conclusion

In spite of the high intuitive appeal vicarious trauma has for clinicians, critical questions remain regarding the construct and divergent validity of vicarious trauma. It seems that before organizations/individuals begin adopting intervention strategies to help address this issue among therapists, further research needs to confirm the existence of a unique phenomenon and develop more sensitive assessment tools that accurately measure and clearly differentiate vicarious trauma from other work related stress responses such as burnout. A crucial step towards clearly understanding and/or addressing the experience of traumatic stress among therapists is likely to involve longitudinal research that explores the importance of therapist characteristics and pre-morbid functioning in the development

of traumatic stress responses across a variety of client populations. Emerging empirical attention on the role of empathy and attachment in the development of traumatic stress among mental health professionals also appears to be a fruitful avenue of research in contributing to our understanding of how professionals providing counselling can be affected by their work.

It appears that some professionals providing counselling may be at risk for developing stress responses to clinical work regardless of the client populations they work with. Although the primary purpose of this study was to investigate vicarious trauma and burnout among professionals providing counselling services, attention must be given to the fact that the majority of participants in this study did not appear to be experiencing either traumatic stress symptoms nor burnout. In fact, the majority of participants appeared to be coping well with the emotional demands of their work and the practicalities of their work settings. A vital aspect in understanding the impact counselling has on the treatment provider may be the resilience and not the vulnerability they possess to experiencing traumatic stress responses. Examining how professionals working with challenging populations such as traumatized clients find a sense of meaning and reward from their work may offer us a more complete understanding of how mental health professionals can not only survive clinical practice, but thrive in their profession.

Table 3 – 1

Demographic Information for Group One: Sexual Violence (n=86)

Gender	
Male	5.8%
Female	94.2%
Highest Degree Obtained	
Diploma/Certificate	15.1%
Bachelors Degree	32.6%
Graduate Degree	50.0%
Other	2.30%
Professional Designation	
Therapist/Counsellor	45.9%
Social Worker	43.5%
Nurse	1.2%
Psychologist	2.4%
Psychiatrist	0%
Pastoral Counsellor	0%
Other	5.9%
Average Time in Field	9.09yrs
Average Time Primary Population	7.24yrs
Work Setting	
Hospital	11.6%
Community Organization	62.8%
School/University	3.5%
Multiple Settings	17.4%
Other	4.7%
Individual vs. Group Work	
Mostly Individual Contact	80.2%
Mostly Group Work	1.2%
Both Individual & Group Work	18.6%
Received Specialized Training	
Yes	90.7%
No	9.3%
How Training Was Acquired	
Not Applicable	8.1%
Employing Agency	4.7%
Workshops/Conferences	15.1%
Academic Institution	4.7%
Combination of Above	64.0%
Other	3.5%
Training Adequate to Work with Primary Population	
Not Applicable	8.1%
Not at All	0%
Minimally	4.7%
Moderately	65.1%
Profoundly	22.1%
Training Adequate to Prepare for Personal Impact of the Work	
Not Applicable	8.1%
Not at All	0%
Minimally	31.4%
Moderately	43.0%
Profoundly	17.4%
Exposure to Traumatic Material	
None at All	0%
Minimal Amounts	3.5%
Moderate Amounts	54.7%
Profound Amounts	41.9%
Exposure to Human Cruelty	
None at All	0%
Minimal Amounts	3.5%
Moderate Amounts	41.9%
Profound Amounts	54.7%
Currently Supervised	
Yes	65.9%
No	34.1%
Supervision Experience	
Not Applicable	34.1%
Addresses Treatment Issues	7.1%
Addresses Treatment Issues and Personal Impact of Work	55.3%
Other	3.5%
Addressed Impact in Personal Therapy	
Yes	57.0%
No	43.0%
Venue to Address Impact of work	
Yes	89.3%
No	10.7%
Experienced A Traumatic Stressor	
Yes	67.4%
No	32.6%
Traumatic Stressor Type	
Not Applicable	34.9%
Sexual Violence	18.6%
Domestic Violence	4.7%
War Veteran	0%
Other	9.3%
Combination of Above	32.6%
Work Considered Traumatizing	
Yes	83.7%
No	16.3%

Table 3 – 2

Demographic Information for Group Two: Psycho-oncology (n=64)

Gender	
Male	17.2%
Female	82.8%
Highest Degree Obtained	
Diploma/Certificate	1.6%
Bachelors Degree	28.1%
Graduate Degree	65.6%
Other	4.7%
Professional Designation	
Therapist/Counsellor	7.9%
Social Worker	65.1%
Nurse	4.8%
Psychologist	12.7%
Psychiatrist	1.6%
Pastoral Counsellor	3.2%
Other	4.8%
Average Time in Field	14.41yrs
Average Time Primary Population	8.27yrs
Work Setting	
Hospital	65.2%
Community Organization	4.7%
School/University	0%
Multiple Settings	14.1%
Other	18.8%
Individual vs. Group Work	
Mostly Individual Contact	82.8%
Mostly Group Work	0%
Both Individual & Group Work	17.2%
Received Specialized Training	
Yes	90.6%
No	9.4%
How Training Was Acquired	
Not Applicable	9.4%
Employing Agency	4.7%
Workshops/Conferences	25.0%
Academic Institution	6.3%
Combination of Above	54.7%
Other	0%
Training Adequate to Work with Primary Population	
Not Applicable	9.4%
Not at All	0%
Minimally	7.8%
Moderately	56.3%
Profoundly	26.6%
Training Adequate to Prepare for Personal Impact of the Work	
Not Applicable	9.4%
Not at All	4.7%
Minimally	26.6%
Moderately	42.2%
Profoundly	17.2%
Exposure to Traumatic Material	
None at All	4.7%
Minimal Amounts	28.1%
Moderate Amounts	43.8%
Profound Amounts	23.4%
Exposure to Human Cruelty	
None at All	26.6%
Minimal Amounts	56.3%
Moderate Amounts	14.1%
Profound Amounts	3.1%
Currently Supervised	
Yes	32.8%
No	67.2%
Supervision Experience	
Not Applicable	68.8%
Addresses Treatment Issues	4.8%
Addresses Treatment Issues and Personal Impact of Work	25.4%
Other	0%
Addressed Impact in Personal Therapy	
Yes	54.7%
No	45.3%
Venue to Address Impact of work	
Yes	87.5%
No	12.5%
Experienced A Traumatic Stressor	
Yes	50.8%
No	49.2%
Traumatic Stressor Type	
Not Applicable	48.4%
Sexual Violence	6.5%
Domestic Violence	3.2%
War Veteran	0%
Other	27.4%
Combination of Above	14.5%
Work Considered Traumatizing	
Yes	51.6%
No	48.4%

Table 3 – 3

Demographic Information for Group Three: General Practice (n=71)

Gender	
Male	26.8%
Female	73.2%
Highest Degree Obtained	
Diploma/Certificate	1.4%
Bachelors Degree	9.9%
Graduate Degree	83.1%
Other	5.6%
Professional Designation	
Therapist/Counsellor	46.4%
Social Worker	17.4%
Nurse	2.9%
Psychologist	24.6%
Psychiatrist	4.3%
Pastoral Counsellor	0%
Other	4.3%
Average Time in Field	11.77yrs
Average Time Primary Population	9.49yrs
Work Setting	
Hospital	2.8%
Community Organization	2.8%
School/University	67.6%
Multiple Settings	16.9%
Other	9.9%
Individual vs. Group Work	
Mostly Individual Contact	95.8%
Mostly Group Work	0%
Both Individual & Group Work	4.2%
Received Specialized Training	
Yes	87.3%
No	12.7%
How Training Was Acquired	
Not Applicable	12.7%
Employing Agency	0%
Workshops/Conferences	21.1%
Academic Institution	18.3%
Combination of Above	39.4%
Other	8.5%
Training Adequate to Work with Primary Population	
Not Applicable	12.7%
Not at All	0%
Minimally	1.4%
Moderately	49.3%
Profoundly	36.6%
Training Adequate to Prepare for Personal Impact of the Work	
Not Applicable	12.7%
Not at All	0%
Minimally	1.4%
Moderately	49.3%
Profoundly	36.6%
Exposure to Traumatic Material	
None at All	2.8%
Minimal Amounts	57.7%
Moderate Amounts	35.2%
Profound Amounts	4.2%
Exposure to Human Cruelty	
None at All	5.6%
Minimal Amounts	62.0%
Moderate Amounts	28.2%
Profound Amounts	4.2%
Currently Supervised	
Yes	52.9%
No	47.1%
Supervision Experience	
Not Applicable	47.1%
Addresses Treatment Issues	12.9%
Addresses Treatment Issues and Personal Impact of Work	38.5%
Other	1.5%
Addressed Impact in Personal Therapy	
Yes	45.1%
No	54.9%
Venue to Address Impact of work	
Yes	91.5%
No	8.5%
Experienced A Traumatic Stressor	
Yes	53.5%
No	46.5%
Traumatic Stressor Type	
Not Applicable	46.5%
Sexual Violence	12.7%
Domestic Violence	2.8%
War Veteran	0%
Other	26.8%
Combination of Above	11.3%
Work Considered Traumatizing	
Yes	36.6%
No	63.4%

Table 3 - 4

Mean Scores and Standard Deviations for Participants on Dependent Measures

	Group One Sexual Violence	Group Two Psycho-oncology	Group Three General Practice	Total Sample (N = 221)
Traumatic Stress Institute Belief Scale	146.65 (27.24)	138.10 (25.96)	140.71 (28.28)	141.27 (26.27)
Impact of Events Scale Total	16.47 (14.44)	16.07 (11.12)	13.14 (12.91)	15.22 (13.08)
Intrusion	8.29 (7.10)	8.10 (6.10)	6.54 (6.17)	7.65 (6.54)
Avoidance	8.28 (8.21)	7.82 (6.51)	6.61 (7.39)	7.59 (7.48)
Emotional Exhaustion	21.41 (13.61)	18.94 (9.46)	18.54 (8.36)	19.27 (9.48)
Depersonalization	4.96 (3.88)	3.19 (4.02)	4.42 (4.07)	4.27 (4.03)
Personal Accomplishment	40.90 (4.38)	41.71 (4.47)	41.79 (4.20)	41.38 (4.30)
Spiritual Well Being Total Score	89.56 (16.92)	94.31 (14.75)	85.79 (17.85)	91.58 (17.45)
Religious Well Being	41.44 (14.01)	45.02 (13.31)	37.39 (15.86)	40.96 (14.69)
Existential Well Being	48.49 (6.30)	49.10 (5.71)	48.82 (4.97)	50.86 (6.69)

Table 3 - 5

Pearson Product – Moment Intercorrelations Among Dependent Variables

Variable	2	3	4	5	6	7	8	9	10
1. TSI Total	.200**	.220**	.160*	.296**	.325**	-.337**	-.147	-.013	-.426**
2. IES Total	1	.200**	.943**	.391**	.193**	-.019	.068	.070	-.018
3. Intrusion		1	.743**	.385**	.170*	-.031	.055	.050	-.022
4. Avoidance			1	.336**	.183**	-.018	.093	.097	-.007
5. Emotional Exhaustion				1	.471**	-.150*	-.030	.022	-.217**
6. Depersonalization					1	-.171*	-.114	-.070	-.209**
7. Personal Accomplishment						1	.120	.063	.251**
8. SWB Total							1	.950**	.529**
9. Religious Well Being								1	.237**
10. Existential Well Being									1

* $p < .05$ ** $p < .01$ N = 221

Table 3 - 6

Proportions of Participants Across Groups on Levels of Depersonalization

	Levels of Depersonalization		
Participant Groups	Low	Moderate	High
Group 1: Sexual Violence (n=85)	68.2% (n= 58)	28.2% (n= 24)	3.5% (n=3)
Group 2: Psycho-oncology (n=64)	87.5% (n=56)	7.8% (n=5)	4.7% (n= 3)
Group 3: General Practice (n=71)	76.1% (n=54)	16.9% (n=12)	7.0% (n=5)
Entire Sample N=220	76.4% (n=168)	18.6% (n=41)	5.0% (n=11)

Table 3 – 7

Demographic Information for Participants with TSI > 167 (n=35)

Gender	
Male	11.4%
Female	88.6%
Highest Degree Obtained	
Diploma/Certificate	8.6%
Bachelors Degree	22.9%
Graduate Degree	68.6%
Other	0%
Professional Designation	
Therapist/Counsellor	38.2%
Social Worker	50.0%
Nurse	0%
Psychologist	11.8%
Psychiatrist	0%
Pastoral Counsellor	0%
Other	0%
Average Time in Field	10.20yrs
Average Time Primary Population	8.57yrs
Work Setting	
Hospital	22.9%
Community Organization	28.6%
School/University	14.3%
Multiple Settings	28.6%
Other	5.7%
Individual vs. Group Work	
Mostly Individual Contact	85.7%
Mostly Group Work	0%
Both Individual & Group Work	14.3%
Received Specialized Training	
Yes	91.4%
No	8.6%
How Training Was Acquired	
Not Applicable	8.6%
Employing Agency	8.6%
Workshops/Conferences	28.6%
Academic Institution	0%
Combination of Above	54.3%
Other	0%
Training Adequate to Work with Primary Population	
Not Applicable	8.6%
Not at All	0.0%
Minimally	5.7%
Moderately	68.6%
Profoundly	17.1%
Training Adequate to Prepare for Personal Impact of the Work	
Not Applicable	8.6%
Not at All	0%
Minimally	34.3%
Moderately	48.6%
Profoundly	8.6%
Exposure to Traumatic Material	
None at All	0%
Minimal Amounts	25.7%
Moderate Amounts	51.4%
Profound Amounts	22.9%
Exposure to Human Cruelty	
None at All	2.9%
Minimal Amounts	45.7%
Moderate Amounts	34.3%
Profound Amounts	17.1%
Currently Supervised	
Yes	54.3%
No	45.7%
Supervision Experience	
Not Applicable	45.7%
Addresses Treatment Issues	11.4%
Addresses Treatment Issues and Personal Impact of Work	37.1%
Other	5.8%
Addressed Impact in Personal Therapy	
Yes	57.1%
No	42.9%
Venue to Address Impact of work	
Yes	85.3%
No	14.7%
Experienced A Traumatic Stressor	
Yes	77.1%
No	22.9%
Traumatic Stressor Type	
Not Applicable	22.9%
Sexual Violence	14.3%
Domestic Violence	2.9%
War Veteran	0%
Other	34.3%
Combination of Above	25.7%
Work Considered Traumatizing	
Yes	77.1%
No	22.9%

Table 3 - 8

Descriptive Statistics for Participants with High TSI Scores Across Dependent Measures

	Mean	Standard Deviation	Range
Traumatic Stress Institute Belief Scale	182.83	13.30	168 - 227
Impact of Events Scale Total	20.23	14.45	0 - 55
Intrusion	10.29	7.72	0 - 33
Avoidance	9.94	7.63	0 - 25
Emotional Exhaustion	26.23	10.61	8 – 48
Depersonalization	6.69	4.73	0 – 16
Personal Accomplishment	39.11	4.80	21 – 47
Spiritual Well Being Total Score	86.88	17.03	52 – 107
Religious Well Being	41.43	13.10	12 – 59
Existential Well Being	44.97	6.55	31 – 60

Table 3 - 9

Pearson Product – Moment Intercorrelations Among Dependent Variables for Participants with High TSI Scores

Variable	2	3	4	5	6	7	8	9	10
1. TSI Total	.151	.106	.178	.537**	.382*	-.035	-.275	-.150	-.280
2. IES Total	1	.943**	.941**	.487**	.197	.214	.158	.081	.241
3. Intrusion		1	.775**	.520**	.255	.123	.092	.017	.185
4. Avoidance			1	.396*	.114	.281	.211	.140	.271
5. Emotional Exhaustion				1	.563**	-.051	-.172	-.087	-.290
6. Depersonalization					1	-.058	-.043	-.071	-.109
7. Personal Accomplishment						1	.116	.020	.306
8. SWB Total							1	.935**	.698**
9. Religious Well Being								1	.398*
10. Existential Well Being									1

* $p < .05$ ** $p < .01$ N = 221

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CHAPTER 4

Professionals' Perceptions of the Rewards of Providing Treatment to Sex Offenders

Background

Providing psychological treatment to sex offenders is challenging work. Professionals providing these services deal with multiple stressors associated with the characteristics of this clientele (Farrenkopf, 1992; Layton, 1988; Polson & McCullom, 1995; Strasburger, 1986), complex counter-transference reactions (Hill, 1995; Mitchell & Melikian, 1995; Polson & McCullom, 1995; Scott, 1994) and situational difficulties in their workplaces specific to this client population (Ellerby, 1997; O'Connell, Leberg & Donaldson, 1990; Ryan & Lane, 1991). The unique dynamics of offender treatment are beginning to be identified as potential sources of burnout, compassion fatigue and vicarious trauma (Bird Edmunds, 1997; Blanchard, 1995; Farrenkopf, 1992; Jackson, Holzman, Barnard & Paradis, 1997; Rich, 1997). Consequently, inquiry into how treatment providers experience and are affected by clinical work with sex offenders has focused largely on the potential for psychological, emotional and spiritual harm (Bird Edmunds, 1997; Ellerby, 1997; Ennis & Horne, 2003; Jackson et al., 1997; Kadambi, 1998; Rich, 1997). Comparatively little attention has been given to how these professionals rise to meet the challenges of working with offenders and how they experience positive and meaningful aspects of their work.

Although the potential for harm certainly is intuitively apparent in this population, researchers investigating the negative effects of working with sex offenders have failed to demonstrate that this professional group is at higher risk for adverse coping, burnout or traumatic stress in comparison to professionals providing psychological services to other

populations. In fact, several studies and descriptive reports have suggested that the majority of professionals treating this client population are coping well with the demands of their work on personal and professional levels (Ellerby, 1998; Ennis & Horne, 2003; Farrenkopf, 1992; Kadambi, 1998; Peaslee, 1995). Researchers suggest that therapists providing services to sex offenders employ a wide range of coping strategies within and outside their work setting to deal with the effects of their work (Ellerby, 1998; Farrenkopf, 1992). Professionals have identified supervision, personal therapy, separating their work from their personal life, developing a detached concern for offender clients and receiving support from other therapists involved with sex offender treatment as important components of coping strategies that enable them to continue their work and cope with the impact it may have on them (Ellerby, 1998; Ennis & Horne, 2003; Farrenkopf, 1992; Jackson et al., 1997; Kadambi, 1998).

Despite the current emphasis on the deleterious effects of working with sex offenders, the same researchers have noted that many of these professionals report a great sense of satisfaction and enjoyment from clinical work with this population (Farrenkopf, 1992; Kadambi, 1998; Mitchell & Melikian, 1995). Of the few studies that have commented on the positive aspects of clinical work with sex offenders, a consistent anecdote is that these professionals tend to experience a strong sense of meaning, purpose and an overriding belief their work contributes to the prevention of further sexual violence (Farrenkopf, 1992; Jackson et. al 1997).

In the most comprehensive study to date investigating the effects of providing sex offender treatment, Ellerby (1998) calls attention to the fact that much of what has been written about the experiences of this professional group has been anecdotal. He also

highlights the fact that there has been no research to explore factors that mitigate the negative impact of providing treatment to sex offenders. As part of his investigation to understand the experiences of these professionals, Ellerby (1998) surveyed 683 professionals providing treatment services to sex offenders and assessed levels of burnout, stress and personal resources. On measures of burnout, professionals working with sex offenders in this study showed similar levels of burnout compared to a larger normative sample of mental health professionals (Maslach, Jackson & Leiter, 1996). Collectively, professionals in this study were found to be at very low risk for the experience of burnout and were coping well with the demands of providing sex offender treatment. Feedback from focus groups conducted by Ellerby (1998) addressing the rewarding and satisfying aspects of providing sex offender treatment indicated that professionals viewed their work as professionally and emotionally fulfilling, exciting/challenging, and saw their efforts contributing to the change process within sex offender clientele and ultimately, to public safety.

To date, no published research has directly examined the sense of reward professionals working with sex offenders experience from their clinical practice. This is somewhat surprising in light of their apparent level of emotional health and coping, in working with such a therapeutically complex client population. The intention of this study was to examine professionals' experience of reward from providing treatment services to sex offenders. Focusing attention on this aspect of these professionals' experience may assist in better understanding their apparent resilience, as well as identifying protective or mitigating factors that may serve to offset the potential harm of providing treatment to sex offenders.

To investigate what professionals working with offenders find rewarding about their work, we surveyed a sample of professionals presently working exclusively with sex offenders in Canada. We asked them to respond to an open-ended question about the rewards of their work, and then had them identify the categories that comprised their experience. We did so by using concept-mapping.

Concept-mapping is a research method that combines qualitative and quantitative strategies and actively involves research participants in generating items and gathering data (Trochim, 1989, 1993). It is particularly appropriate for clarifying the domain, constituent elements, and underlying structure of a phenomenon as experienced by the population of interest (Trochim, 1989). Procedurally, concept mapping involves three basic processes: (a) generation of ideas, thoughts, or experiences by participants about a specific question or self-report; (b) grouping together the ideas, thoughts, or experiences through an unstructured card sort of the participants; and (c) statistical analysis of the card sort results using multidimensional scaling to suggest the organisational principles implicit in the participants' sorting (Davison, Richards, & Rounds, 1986) and cluster analysis to depict conceptually similar groups of sorted items (Borgen & Barnett, 1987).

Given that the participants sort the meaning units, investigator bias is reduced in contrast to qualitative data that is sorted into themes by one or more investigators. Bias is further reduced through statistical analysis of the participant-determined groupings, making it unnecessary for either the participants or the investigators to specify any of the psychological dimensions or attributes in the sorting of the data. The identification of underlying psychological dimensions as reflected in the participants' experience can take place from the concept maps obtained by scaling and clustering (Rosenberg & Kim,

1975). Concept mapping was therefore employed to answer the question of what professionals find rewarding about providing psychological treatment services to sex offenders.

Method

Participants

Professionals currently providing sex offender treatment across five Canadian provinces were contacted in two phases to participate in this study. In the first phase, 220 individual surveys containing demographic questions, quantitative measures from a larger research project, and the open-ended question, "What are the positive aspects or rewards that motivate you to provide and continue to provide treatment services to sex offenders?" were distributed. Ninety-three surveys were returned, for a response rate of 43%. Two surveys were provided by individuals who did not work predominantly with sex offenders, and nine did not respond to the open-ended question. The total sample in the first phase thus comprised 83 treatment providers: 38 male and 45 female. Participants' mean age was 43 years, with a range of 25 - 57 years. Of the sample, 25% had diploma or certificate, 34% had Bachelor's degrees, 30% had Masters' degrees, 10% had a doctorate degrees, and 1% had a medical degree. Seventy four percent of the sample had received specialized training in sex offender treatment. Sixty - eight percent of the sample had five or more years experience providing treatment to sex offenders.

In the second phase, 30 professionals currently providing sex offender treatment across Canada were contacted (see Appendices G and H) and asked to sort (see Appendix I) and rate the statements derived from phase one (see Appendix J). Twenty-four of these individuals participated in the sorting of statements for a response rate of 80%. Of these

participants, 20 rated the statements in terms of their perceived importance.

Procedure

During the first data-gathering phase, participants were asked to respond to the following open-ended probe: "What are the positive aspects or rewards that motivate you to provide and continue to provide treatment services to sex offenders?" The probe was designed to elicit participants' perspectives on their experience without overly constraining their response. Using Giorgi's (1985) four-level scheme as a procedural guideline, a three-member research team met as a group to analyze participants' responses. The intent of this analysis was to distill an inclusive set of statements that captured the essence of the participants' experience while retaining their language. This involved intensive scrutiny of each participant's response primarily by grammatical rules that demarcated separate sentences and by taking into account content and meaning of the response, in order to identify statements that represented a discreet idea. Next, contextual or irrelevant material was separated from statements potentially relevant to the experience of what was rewarding and discarded. Statements that retained participants' language and completely reflected the domain of their experience were initially identified. These statements were next compared with each other in order to identify redundancies, resulting in a final list of 83 non-redundant qualitative description statements of what participants found rewarding about providing treatment to sex offenders.

In the second data-gathering phase, 24 participants completed the sorting task and 20 participants completed the rating task. For the sorting task, each of the 83 statements derived from the qualitative analysis was printed on a card; so that each card represented

one qualitative description of what professionals found rewarding about working with sex offenders. Participants were asked to place the 83 cards in piles according to "how they seem to go together." No restrictions were placed on participants' sorting strategies other than that they not place each item card alone in a pile or place all cards in one pile (Rosenberg & Kim, 1975).

For the rating task, the 83 rewarding items from the qualitative analysis were compiled into a questionnaire in which participants rated each on a five-point scale ranging from 1 (not important) to 5 (extremely important). The intent of this procedure was to enable identification of the relative importance of the rewarding aspects of providing treatment to sex offenders.

Results

A nonmetric multidimensional scaling (MDS) procedure was performed on the data from the sorting task. MDS arranges points representing items along orthogonal axes such that the distance between any two points reflects the frequency with which the items were sorted together, making it especially suitable for spatially representing unknown latent relationships among variables (Fitzgerald & Hubert, 1987; Kruskal & Wish, 1978). The MDS procedure resulted in a final stress value of .30 for a two-dimensional solution, which is reasonably stable (Kruskal & Wish, 1978). The stress value is an index of the stability of an MDS solution and ranges from 0 (perfectly stable) to 1 (perfectly unstable). The selection of a two-dimensional solution is also appropriate given that the primary purpose of the MDS configuration is to display clustering results visually, which is difficult to do in three or more dimensions (Kruskal & Wish, 1978).

Hierarchical cluster analysis of the MDS similarity matrix was then used to group

sorted items into internally consistent clusters, this cluster solution being superimposed on the MDS point plot. Ward's (1963) minimum variance method was used to optimize distinctiveness across clusters (Borgen & Barnett, 1987). The research team then met as a group to reach consensus about a descriptive and justifiable name for each of the clusters of MDS items based on inspection of the constituent items. Because the cluster solution is based upon estimated distances between items from the MDS two-dimensional solution, the cluster solution was used as a secondary guide to interpreting the map, with the MDS solution (i.e., the relative distance and position of items on the map) given primary consideration. The names of each cluster were assigned by the research team in consideration of the items making up the clusters, inspection of those items contributing most to the uniqueness of each cluster, and relative distance of each item from other items on the map. As with other procedures, such as factor analysis, naming of clusters is both statistically and conceptually influenced. Interpretation of the concept map involves informed conjecture about the possible structure participants imposed on the items in their sorting (Kunkel & Newsom, 1996). Initial examination of the map involves attempts to identify implicit dimensional axes around which points may be configured (Buser, 1989). Inspection of the placement and adjacency of statements and clusters can also be helpful in this process to identify apparent regions of the map and potentially related concepts. The cluster structure can also be understood in terms of adjacency of constructs, with the close placement of statements reflecting the participants' perception of them as similar.

The concept map of the 83 rewarding aspects of sex offender treatment is presented in Figure 4-1. Each of the 83 statements derived from the participants'

phenomenological response are represented as a point on the map. The relative position of the points from one another is derived from the MDS solution and reflects the frequency with which the statements were sorted together by participants; points that are closer together represent statements that were more frequently sorted together than were statements represented by points farther apart. The cluster boundaries around groups of points represent statements that were more frequently sorted together in the same pile and less often sorted with statements in other piles.

Bridging values can range from 0 to 1 and depict how frequently statements were sorted together, with lower values indicative of statements sorted together frequently and higher values indicating statements sorted together less frequently based upon estimated distances between statements from the MDS two dimensional solution. Statements with a high bridging value indicate that a statement bridges two or more clusters to which it is related. Statements with a bridging value of 1 suggest that this item could potentially be sorted with every cluster. A low bridging value means that the statements in that cluster were more frequently sorted with statements within the cluster than with statements in other clusters. Rating values range from 1 to 5 and represent the importance participants placed on each statement. Low values reflect statements experienced as less important and higher values reflect correspondingly more important rewards of working with sex offenders.

The final concept map generated seven distinct cluster themes which were labeled; Protection of the Public, Socially Meaningful Curiosity, Enjoyment of Counselling, Professional Benefits, Colleagues, Offender Change and Wellness and finally, Offending Specific Change. A statement key, statements within each cluster, and

descriptive statistics for each statement and cluster are presented in Table 4-1.

Cluster 1, Protection of the Public consisted of statements alluding to the belief that sex offender treatment contributed to public safety (e.g., "Protecting the community, To reduce the incidence of sexual abuse, The feeling that if one victim can be prevented it will all be worthwhile"). This cluster had the highest rating value, indicating that participants felt that this aspect was the most important of all rewards of providing treatment to offenders. Cluster 2, Socially Meaningful Curiosity, comprised statements relating to professional's sense of being stimulated and rewarded by the academic and clinical challenges of this population (e.g., "Great exposure to real pathologies and disorders, I find clinical and research related activities with this population fascinating, Being able to correct some of the public's misconceptions that hinder successful management of sex offenders"). While this cluster had the highest bridging value, it contained an outlier statement (number 48, "No one else will do it") that is likely to have distorted the bridging value.

Statements relating to the rewards of providing counselling services made up Cluster 3, Enjoyment of Counselling (e.g., "I enjoy counselling, Being part of the metamorphosis of change and accountability, I enjoy teaching, I feel I am doing something very worthwhile"). Pragmatic statements surrounding the rewards associated with benefit packages, working environments and opportunities for professional advancement were captured in Cluster 4, Professional Benefits (e.g., There is a large degree of autonomy associated with the work, I am paid well with good benefits, Variety and flexibility in my work schedule, Ability to focus on an area of specialty and become an expert in the field"). Of all clusters, Professional Benefits received the lowest rating

value, indicating that participants rated the rewards associated with this theme as less important than those within other cluster themes.

Cluster 5, Colleagues, consisted of statements related to rewards stemming from personal and professional relationships with coworkers and being a part of an effective treatment team (e.g., "My colleagues are knowledgeable, ethical and industrious people, The co-workers in my team are excellent to work with, Teaching and learning from colleagues, We are a well functioning team"). A low bridging value was found for this cluster, indicating that the individual items within this cluster were sorted together more frequently in comparison to items in other cluster themes. As evidenced by the spatial separateness of this cluster within the map, this suggests quite a distinct area of reward for these professionals.

The statements comprising clusters 6 and 7 were particularly interesting. Cluster 6, Offender Change and Wellness contained a majority of statements relating to the rewards of assisting this population in improving psychological and social wellness (e.g., Witnessing improvements in someone's quality of life, Helping offenders to live productive lives, Watching the progress to more pro-social individuals"). This cluster had the lowest bridging value overall, which again suggests a distinctive thematic dimension. Cluster 7 statements; Offence Specific Change, were more specific to a sense of reward attained from professionals' perceived impact on offense related change and a belief in the prevention of re-offence through treatment (e.g., Breaking the cycle of abuse, I believe that my work assists the offender to recognize their crime cycle and prevention strategies, Upholding belief that treatment for sex offenders can be effective"). A particularly surprising finding was participants rating of importance for

these respective cluster themes. Offender Change and Wellness achieved a much higher rating value than Offence Specific Change. In fact, Offender Change and Wellness ranked second to Protection of the Public in terms of the importance professionals assigned to the statements within this cluster. Rewards associated with Offending Specific Change in comparison, was rated much lower, ranking 5th relative to all other cluster themes.

Examination of the top and bottom portions of the map in Figure 4-1 reveals that treatment providers' experiences of the rewarding aspects of offender treatment appear to move from rewards associated with counselling on the whole, to more specific rewards associated with offender clientele. Enjoyment of Counselling, Professional Benefits, and Colleagues (clusters 3, 4, and 5 respectively) comprise the upper quadrant of the map. Taken together, much of the statement content in these clusters reflected personal and professional rewards taken from their work environments, colleagues and interpersonal contact with others that are common sources of reward for many helping professionals (Dlugos & Friedlander, 2001; Farber & Heifetz, 1981; Shapiro, Burkey, Dorman & Welker, 1996). The bottom portion of the map, however, appears to reflect rewards that are highly specific to working with sex offender clientele. Protection of the Public, Socially Meaningful Curiosity, Offender Change and Wellness and Offending Specific Change (clusters 1, 2, 6, and 7 respectively) were the clusters contained in this portion of the map.

One interesting finding was the identification of what the research team labeled a "Treatment Belief Zone" at the center of the map that crossed several cluster boundaries. Several statements from within the center portion of the map reflect a core area of reward

associated with a belief in treatment effectiveness and in the value of providing it to this population on personal and societal levels. Statements from this area of the map included; "To reduce the chance of the offender hurting anyone else. The feeling that if one victim could be prevented it will all be worthwhile, Dealing within an area that has profound and far reaching effects on others, Finding ways to demonstrate effective treatment, It requires engagement of intellectual, spiritual, social and psychological issues; I feel my clinical skills are challenged to the fullest, Our program is successful in terms of completion, Upholding belief that treatment for sex offenders can be effective."

An additional way of conceptualizing the map is by visualizing various portions of the map as comprising distinct areas of where these professionals were able to gather a sense of reward and meaning in their work. Clusters 3, 4, and 5 appear to comprise an area that reflects what professionals are taking away from or being provided by their work with offenders. In other words, this area reflects rewards obtained as a result of the perceived direct benefit to themselves on personal or professional levels. How society benefits from their work and the rewards associated with those benefits appears to be captured in the area of the map containing clusters 1 and 2. The remaining clusters 6 and 7 reflect the rewards directly associated with how professionals feel offender clientele are able to benefit from the treatment they are provided.

Discussion

Despite the well-documented challenges associated with sex offender treatment and the potentially negative personal and professional sequelea that individuals working with this population may experience, participants in this study were well able to identify clear rewards associated with their work. The concept map generated by the participants

in this study identifies seven distinct themes of what professionals providing services to sex offenders find rewarding. Conceptualized on a more global level, the reported rewarding aspects of sex offender treatment could also be grouped in terms of rewards associated with perceived benefits of the work for the professional themselves, the societal contributions of their clinical work and finally the perceived benefits of their work to individual offender clients.

The most important perceived rewards from clinical work with sex offenders were those associated with the belief that the work they did contributed to the protection of the public and the prevention of future victims of sexual violence. Rewards associated with pragmatic work related benefits such as wage or time off, were considered the least important rewarding aspect of their work in comparison to other themes they identified. Themes that were generated were consistent with previous research and anecdotal reports of these professionals' experience of reward from their clinical work (Ellerby, 1998; Farrenkopf, 1992; Mitchell & Melikian, 1995). Concomitant with satisfactions common to many professionals who provide psychological services, there were also clear rewards specific to sex offender clientele.

One unique dimension of these professionals' experience of reward from their clinical work is that they appear to be once removed from rewards associated with the perceived direct benefits their work has for sex offender clients. It is curious that when one compares the ratings of cluster themes, the rewards associated with the perceived benefits their work has for society were consistently viewed as more important than rewards associated with how offender clients were directly helped by the treatment they provided. In this sense, their experience may be different from professionals providing

psychological services to other client populations who appear to be motivated by how their individual clients change and grow (Farber & Heifetz, 1981; 1982). For sex offender treatment providers, a primary motivation to engage in clinical work appears to take a much broader focus in that they work largely to affect the functioning of a community as opposed to the individual. While this perspective appears to contribute greatly to their sense of meaning and contribution of their work, it may also fuel the ongoing struggle this professional group appears to have in clearly defining who their "client" is in sex offender treatment (Hill, 1995).

A possible connection to this interesting aspect of their experience of reward from clinical work could be related to a theme of greater empathic distance between the therapist and the sex offender client than with other types of clients. Sex offender treatment providers face a multitude of well-documented challenges in establishing and maintaining therapeutic rapport with offender clientele (Farrenkopf, 1992; Hill, 1995; Mitchell & Melikian, 1995). Hill (1995) for example, poses the notion of triadic counter-transference for therapists working with forensic clients. He argues that therapists working with mandated forensic clients often experience numerous counter-transference reactions to their offender clients, their previous/possible victims, and the demands of the systems in which they work or are responsible too. The competing demands of their clients, their potential victims and their work setting are often incompatible with one another and serve to interfere with the ability to develop and maintain an empathic connection with offender clients often resulting in a connection that is more emotionally distant than with other client populations (Hill, 1995). This corresponds with anecdotal and descriptive reports from treatment providers who report a sense of connection and

professional responsibility to the victims of their clients and to the systems (judicial, correctional) that function to protect society against their clients' behavior (Ellerby, 1997; Farrenkopf, 1992; Mitchell & Melikian, 1995; Polson & McCullom, 1995)

The empathic distance from offender clients has been viewed by some as a potentially negative influence on the establishment of therapeutic rapport and the successful treatment of sex offenders (Marshall, Anderson & Fernandez, 1999; Peaslee, 1995). Others, however, suggest that in fact, a healthy detached concern for sex offender clients is a highly adaptive skill for professionals working with this population over the long term (Ellerby, 1998; Farrenkopf, 1992; Kadambi, 1998). These findings may relate to the experience of reward for participants in that a deep sense of responsibility to the victims of offenders, coupled with a more distant empathic connection, may diminish the perceived importance of rewards associated with how offender clients directly benefit from treatment and may heighten the importance of rewards associated with how treatment benefits the public. It remains unclear at this point, however, as to how the empathic connection with sex offenders may affect the emotional health of professionals and the impact it may have on the effectiveness of the treatment they provide. Future research in this area may address the tautological bind of whether professionals providing treatment to sex offenders are more empathically distant because so few of their clients respond to treatment, or if sex offenders respond poorly to treatment because their treatment providers encounter difficulty connecting empathically with them.

Literally central in the concept map of the rewards associated with providing treatment to sex offenders was the "treatment belief zone" which appeared to be a core belief that the treatment they were providing was effective and served to contribute to

public safety. This belief appeared to tie many aspects of reward found from their work together. Anecdotal reports and descriptive research also suggest that professionals providing treatment to sex offenders were motivated to continue their work by a belief that offenders were entitled to treatment and that the treatment they provided was effective (Farrenkopf, 1992; Jackson et al., 1997). The findings from this study also appear to be in keeping with empirical studies investigating burnout among these professionals. Results from some studies also have found that in comparison to normative samples of mental health professionals, individuals working with sex offenders exhibit high scores on the Personal Accomplishment subscale that assesses feelings of competence and successful achievement in one's work (Kadambi, 1998; Shelby, Stoddart, & Taylor, 2001).

What makes these findings particularly interesting is that these professionals appear to be quite connected to a sense of competence and find a sense of reward in providing treatment that they consider effective amidst the ambiguity of therapeutic success that surrounds sex offender treatment. Sex offenders are notoriously difficult to treat (Craig, Browne & Stringer, 2003; Hanson, 2000) and "successful treatment" appears to be in a constant state of flux and re-assessment. Commonly, the standard for determining successful treatment for this client population are recidivism rates (Jackson et al., 1997). For sex offenders, researchers have shown that the risk of re-offence following treatment continues throughout the offenders' lifetime (Doren, 1998). In this sense, using re-offence rates as a professional measuring stick for effectiveness could have limited relevance for these professionals.

The ratings of the two cluster themes (clusters 6 and 7) relating to rewards

professionals directly associated with offender clients may speak to a broader concept among these professionals about how rewards associated with successful treatment is considered. Participants in this sample actually differentiated the rewards associated with offender change and wellness from offence specific change and rated the importance of these cluster themes very differently. Professionals rated the rewards associated with contributing to the overall health and wellness of sex offenders as more important than those associated with offence specific change. Although at first glance this finding seems contrary to the primary purpose of sex offender treatment, these results may be reflective of an adaptation process these professionals appear to experience in response to clinical work with sex offenders.

Farrenkopf (1992), found that therapists working with sex offenders passed through several phases of impact associated with their clinical work. Over time, therapists become increasingly aware of challenges relating to offender clients and the difficulties associated with modifying offending behavior. The result of this awareness can lead to therapists into a phase of "erosion" whereby their feelings of anger and resentment towards their offender clients and their behavior increases, leading to a disbelief in the treatment process and ultimately burnout. Alternatively, in response to the realities of offender treatment, Farrenkopf (1992) states that therapists can enter an "adaptive" phase, in which they "regain their work motivation and therapeutic compassion by adopting a more detached attitude, lowering their expectations and philosophically tolerating the human dark side" (p. 221). Using this rationale, professionals working with sex offenders could also facilitate an adaptive response by holding an overriding belief in the ultimate effectiveness of the treatment as it applies to

the population of sex offenders receiving it, and place less importance and emphasis on a belief in individual clients for offence specific change.

The rating importance assigned to clusters 6 and 7 may in fact represent this cognitive shift and adaptive focus on the part of participants. Over two thirds of professionals within this study had been working with offenders over five years. The sheer length of time participants in this sample engaged in treating sex offenders is suggestive of an ability to cope successfully with the demands of the work. How professionals rated the importance of rewards associated with offender change and wellness versus offence specific changes may be reflective of more realistic expectations of offender clients and their own ability to affect offense specific change. Contributing to this theme of adaptation in treating sex offenders, it appears that these professionals are also taking a sense of reward and meaning from their clinical work from aspects of it that are more likely to yield a positive return. What remains unclear however, is how participants can rate the importance of protecting the public as the most important area of reward while ranking the importance of offence specific change fifth of seven thematic clusters.

Rewards associated with a connection to colleagues involved in treating sex offenders were rated as 3rd in terms of importance, more important than the rewards associated with contributing to offence specific change. Collegial support has been consistently identified by researchers as a potential mitigating factor in preventing adverse effects of providing counselling/psychotherapy to many client populations (Dlugos & Friedlander, 2001; Farber & Heifetz, 1981; Mederios & Prochaska, 1988). For sex offender treatment providers, colleagues may have added importance in

providing social support and opportunity to debrief and process negative counter-transference responses to offender clientele (Ellerby, 1998; Ennis & Horne, 2003; Jackson, Holzman, Barnard & Paradis, 1997; Rich, 1997). Collegial relationships among sex offender treatment providers may also offset the feelings of isolation and alienation that may result from the stigma of working with sex offenders and buffer the lack of understanding from colleagues outside this area of practice (Alford, Grey & Atkisson, 1988; Cooke, Baldwin & Howison, 1990).

Of the cluster themes identified, Connection to Colleagues appears to have the most pragmatic implications for individuals and institutions involved in treating sex offenders. The results of this study suggest that in addition to preventing stress and distress among professionals providing sex offender treatment, positive connection to colleagues also serves to promote wellness and is a rewarding and motivating aspect to continue to provide treatment to this client population. Institutions and agencies would appear be well served to engage in activities or programs that promote team building and encourage and maintain good personal and professional relationships between their employees. The inclusion of regular supervision and case conferencing may also provide these professionals with a forum for discussion and opportunities to access support. For isolated professionals (e.g. working in small rural communities), creating and maintaining a collegial support network of other professionals working with sex offenders via on-line discussion groups, professional association memberships etc., may be vital to their satisfaction and longevity in the field.

Conclusion

The purpose of this study was to clarify and identify the rewarding aspects of

providing sex offender treatment. Even in the face of arguably one of the most difficult client populations to work with, professionals appear to be well able to find a sense of meaning and reward from their work that serves to enrich and motivate them to continue treat sex offenders. In addition to rewards commonly associated with the provision of counselling, professionals in this sample identified rewarding aspects of sex offender treatment highly specific to their client population. How important these aspects of reward are as necessary or sufficient conditions in the continuation of providing treatment to sex offenders and how perceptions of reward evolve over time may reflect the next step in investigating these professionals' experience.

Continuing to focus attention on these aspects of reward and satisfaction may assist us in creating a more balanced perspective of how treating sex offenders affect the treatment provider. Further empirical investigation surrounding resilience and coping may also contribute to our understanding of how the majority of professionals treating sex offenders remain emotionally well and continue to deal effectively with the demands associated with sex offender treatment. One possible area of investigation is how collegial relationships function in the promotion of health and the role they may play in the prevention of adverse effects for professionals working with sex offenders. It may also be interesting to compare the role and importance of collegial relationships for professionals working with other client populations in terms of mitigating emotional distress and increasing job satisfaction. In the interim, organizational and individual commitment to work practices that facilitate social support and collegial connections, may serve as a pre-emptive measure in ensuring the health, wellness and satisfaction of these dedicated professionals.

Table 4-1

Clusters and Items From Treatment Providers' Concept Map of What They Found Rewarding About Their Work

Cluster and Item	Bridging Value	Rating (Mean)
Cluster 1: Protection of the Public	**0.50**	**4.12**
1. To reduce the chance of the offender hurting anyone else.	0.38	4.78
8. Providing education about the myths of sexual abuse/offending.	0.48	3.55
25. The feeling that if one victim can be prevented it will all be worthwhile.	0.41	4.50
15. To reduce the incidence of sexual abuse.	0.38	4.75
69. Our program has a low recidivism rate.	0.66	3.75
7. Protecting the community.	0.45	4.50
20. Promotion of safety to the public.	0.52	4.25
47. My motivation is to make my family safer.	0.59	2.85
14. To reduce the possibility of more victims.	0.46	4.90
49. I believe in Correctional Services of Canada mandate to reduce the risk of re-offence through treatment.	0.69	3.37
Cluster 2: Socially Meaningful Curiosity	**0.55**	**3.16**
31. Dealing within an area which has profound and far - reaching effects on others.	0.41	3.70
79. Finding ways to demonstrate effective treatment.	0.45	3.65

37. I make a difference in my community.	0.43	3.65
75. Being able to correct some of the public misconceptions that hinder successful management of sex offenders.	0.45	3.20
76. I feel that I have encouraged other agencies to provide awareness towards prevention of sex offending/sexual abuse.	0.43	3.10
48. No one else will do it.	1.00	2.05
55. Great exposure to real pathologies and disorders.	0.70	2.55
60. I find clinical and research related activities with this population fascinating.	0.51	3.40
Cluster 3: Enjoyment of Counselling	**0.39**	**3.39**
2. I feel that I have helped these clients.	0.40	3.78
74. I feel that I have had a positive impact on the lives of individuals I have worked with.	0.36	3.60
54. I enjoy the therapeutic contact with these clients.	0.41	3.50
16. Being part of the metamorphosis of change and accountability.	0.43	3.45
42. The honor of being party to the transformation of souls.	0.43	2.40
21. I get feedback that the things I do help these clients.	0.44	3.10
59. I feel I can make a difference.	0.37	3.95
43. It requires engagement of intellectual, spiritual, social and psychological issues.	0.46	2.90
28. I enjoy counselling.	0.34	3.90
66. I feel I am doing something very worthwhile.	0.33	3.95
56. These clients bring out the best in me.	0.37	2.55

29. I enjoy teaching.	0.39	3.60
Cluster 4: Professional Benefits	**0.42**	**2.99**
11. There is a large degree of autonomy associated with the work.	0.40	2.95
41. Participating in professionally cutting edge program of sex offender treatment.	0.50	3.40
51. Ability to focus on an area of specialty and become an expert in the field.	0.35	3.40
62. For the experience I gain.	0.31	3.45
65. Variety and flexibility in my work schedule.	0.40	3.05
17. It is challenging work.	0.34	3.75
64. I feel that my clinical skills are challenged to the fullest with these clients.	0.31	3.75
50. Ability to design assessment and treatment programs the way I feel is best.	0.40	2.95
82. I am close to the cutting edge of research.	0.48	2.95
22. The money is good.	0.49	2.32
35. I am paid well with good benefits.	0.48	2.42
30. I receive good financial compensation.	0.51	2.37
81. This work brings status and access to program funds.	0.49	2.16
Cluster 5: Connection to Colleagues	**0.16**	**3.57**
10. I was able to work with a co-facilitator whom I greatly respected.	0.20	3.65
80. I work with highly motivated co-workers.	0.13	3.55
44. The opportunity to work with other dedicated staff.	0.11	3.50

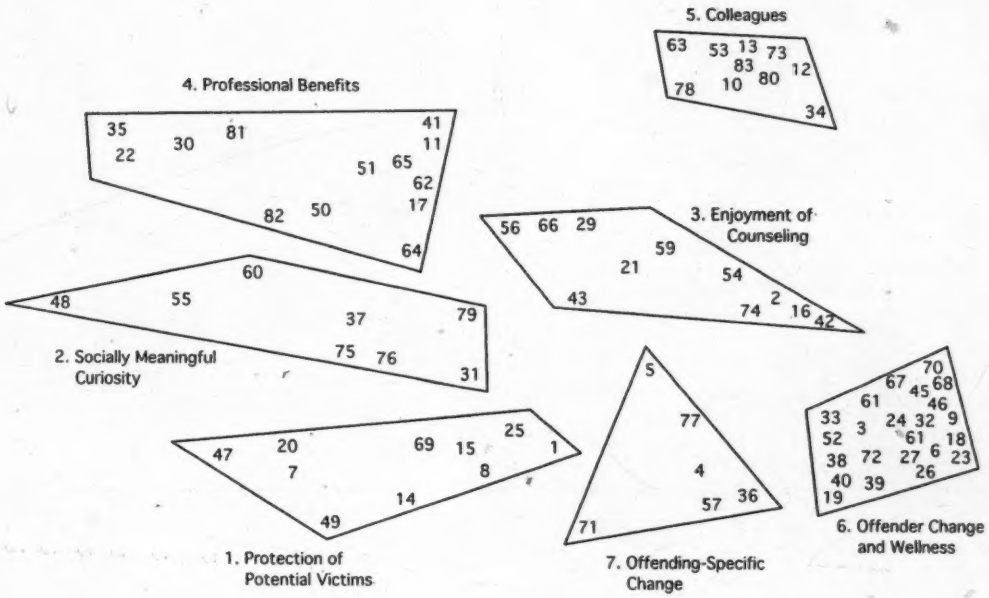
58. The co-workers in my team are excellent to work with.	0.11	3.50
78. Teaching and learning from colleagues.	0.25	3.90
12. My colleagues are knowledgeable, ethical and industrious people.	0.13	3.90
73. The support of the treatment team.	0.13	3.65
13. We are a well functioning team.	0.10	3.80
83. The inspiration and encouragement I feel from other dedicated colleagues.	0.09	3.35
53. Excellent colleagues in the field.	0.12	3.40
63. I get to work with an incredibly talented pool of people.	0.13	3.45
34. I receive positive feedback from members of my treatment team.	0.40	3.20
Cluster 6: Offender Change and Wellness	**0.09**	**3.63**
3. Seeing men engaging positively in treatment over the long term.	0.40	3.45
24. Seeing who offenders can become.	0.40	3.20
33. On rare occasions, I have patients assigned to me who are motivated to change.	0.20	3.35
61. Seeing people excited about learning about themselves and transforming.	0.13	3.00
6. Witnessing improvements in someone's quality of life.	0.01	3.75
18. Helping offenders to live productive lives.	0.00	3.75
23. Watching our clients change over treatment.	0.01	3.75
26. The realization that sex offenders are real people capable of change.	0.05	3.50

27. Seeing offenders' improve their lifestyles.	0.00	3.45
19. To give offenders a better sense of control over their offending.	0.12	4.20
40. Offenders can learn that control is possible.	0.12	4.00
38. Having an offender move away from denial and minimization.	0.10	3.90
52. Offenders can come to recognize their unhealthy lifestyle cycles.	0.10	3.80
39. Seeing the offender gain a more meaningful understanding of the effect their offence has on their victims.	0.08	4.25
72. Intervention can result in a healthy individual.	0.06	3.60
9. Seeing the offender as a person and not a perpetrator	0.12	3.80
32. Some of these men have made mistakes in their lives and have a chance to turn their lives around.	0.07	3.45
45. Being able to observe and participate in others making life changes.	0.13	3.50
46. Helping them heal.	0.11	3.15
67. It is rewarding to see clients taking responsibility for their offence.	0.15	3.85
68. Watching the progress to more pro-social individuals.	0.13	3.65
70. To see someone succeed in their struggle to change.	0.15	3.60
Cluster 7: Offending-Specific Change	**0.41**	**3.35**
4. Breaking the cycle of abuse	0.29	4.45
36. I believe that my work assists the offender to recognize their crime cycle and prevention strategies.	0.21	3.85

57. The phone calls and letters from ex-offenders who are doing well in the community.	0.48	2.00
71. These clients are more secretive and more in denial therefore it becomes a game of lowering these barriers – the "game" is exciting.	0.74	2.40
5. Upholding belief that treatment for sex offenders can be effective.	0.39	3.95
77. Our program is successful in terms of completion.	0.37	3.45

Note. Participants rated each item according to its importance, using a 5-point scale ranging from 1 (not important) to 5 (extremely important

Figure 4-1. Concept map of 83 elements of what 83 sex offender treatment providers found rewarding about their work derived from qualitative analysis of their response to the probe "What are the positive aspects or rewards that motivate you to provide and continue to provide treatment services to sex offenders?" (based on multidimensional scaling and cluster analysis of 24 treatment providers' open-card sort of these elements)


5. Colleagues
63 53 13 73 83 12 78 10 80 34
4. Professional Benefits
35 30 81 41 11 22 51 65 62 82 50 17 64
3. Enjoyment of Counseling
56 66 29 59 21 54 43 74 2 16 42
60 48 55 37 79 75 76 31
2. Socially Meaningful Curiosity
47 20 69 15 25 1 7 8 14 49
1. Protection of Potential Victims
5 77 4 57 36 71
7. Offending-Specific Change
70 67 45 68 61 46 33 3 24 32 9 52 61 18 38 72 27 6 23 40 39 26 19
6. Offender Change and Wellness

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CHAPTER 5

SUMMARY

The research conducted for this dissertation represents a program of research investigating the impact of providing counselling on the helping professional. A review of the research and two separate empirical investigations were undertaken to clarify and understand the experience of professionals providing counselling services to a variety of client populations. The construct of vicarious trauma was initially investigated to determine its validity and applicability to therapists across client populations. There were no differences among professionals working with different types of client populations on measures of traumatic stress and burnout. Results from this study suggest there are critical questions regarding the construct and divergent validity of vicarious trauma that require resolution before definitive statements can be made about the phenomenon, its prevalence and severity.

To complement this investigation and provide a balanced understanding of the impact of counselling on the helping professional, a second investigation was conducted to explore the rewarding and enriching aspects of providing counselling to a particularly challenging client population. A concept map was generated and identified seven distinct themes associated with the rewarding aspects of providing treatment to sex offenders. The findings from this investigation suggested that these professionals were well able to identify clear aspects of reward associated with the perceived protective function of their work and rewards that were specific to their offender clientele. A connection to their colleagues appeared to be a particularly important aspect of reward that professionals associated with their clinical work.

Contributions of the Research

Collectively, the three papers that comprise this dissertation make an original contribution to the field in a number of ways. The critical examination of the construct of vicarious trauma draws attention to aspects of the phenomena only very recently questioned in existing literature (Sabin-Farrell & Turpin, 2003). The first study undertaken in this program of research represents an important exploration of construct and divergent validity of vicarious trauma on conceptual and psychometric levels. The sampling procedures used and inclusion of additional groups for comparison purposes set this study apart from previous examinations of vicarious trauma among therapists.

From this study, two key concerns have emerged that have not been adequately addressed by current researchers. The matter of accurate measurement and construct and divergent validity needs to be addressed if the phenomenon of vicarious trauma is to be investigated further. Researchers have also not consistently demonstrated that they are finding effects of providing counselling that are unique to trauma therapists that support the theory behind vicarious trauma.

Validating the construct of vicarious trauma is a pressing issue if one considers the psychosocial climate following the terrorist attacks of September 11, 2001. Vicarious trauma has been used often in the media/literature as a way of understanding the impact of September 11, 2001 on the collective psyche of Americans and has sparked a flurry of research/discussion on secondary exposure to trauma and its effects (Ahern et al, 2003; Cardenas, Williams, Wilson, Fanouracki & Singh, 2003; Connery, 2003; DeLisi et al, 2003; Eidelson, D'Alessio & Eidelson, 2003; Hoge et al, 2002; Peterson, Nicolas, McGraw, Englert & Blackman, 2002; Rushing & Jean-Baptiste, 2003; Ruzek, 2002;

Schwerin, Kennedy & Wardlaw, 2002; Sullivan, Shapiro & Thompson, 2003; White, 2001; Wirth, 2003). Validation issues are also of premier importance as in most clinical practice settings both financial and human resources are limited. It seems at this point, in light of the concerns with the existing body of research on the construct, resources allotted to address a construct not yet empirically validated or consistently supported may be misappropriated.

The second study in this dissertation offers a significant contribution to the existing literature in combination with the first study and on an individual basis. This investigation may possibly represent the first published study that exclusively focuses on identifying the rewarding aspects of sex offender treatment. In conjunction with helping clarify and understand rewarding aspects of sex offender treatment, the findings of this research highlight aspects of clinical work that may mitigate negative emotional responses to clinical work that may apply to therapists across client populations.

Taken together, these studies revealed two common variables that appear to have a high degree of relevance when investigating and considering how counselling may affect the helping professional, regardless of client population. Therapists' experience of empathy for clients and their perceived level of social support appear to have mitigating and contributory effects on how counselling impacts the professional.

The empathic connection therapists have with clients appears to be the vehicle through which professionals can be affected by clients' presenting issues and transferences. In one sense, close connection to individuals in need of assistance may be a source of a deep satisfaction, reward and meaning in clinical work, which may mitigate associated stressors. In another, empathy can be the wellspring for intense and

overwhelming affect that may serve to elicit traumatic stress responses and trigger emotional disconnection from clientele. Alternatively, empathic connection may at times be appropriately distant from clients whose behavior is difficult to comprehend and whose experience may be emotionally disturbing to connect with. While this may serve as a protective function for the therapist, it remains unclear as to how this may affect the client in the therapy process.

Perhaps interacting with therapists' experience of empathy for their clients in determining their responses to clinical work is their level of social support. The proposed importance of social support in protecting mental health professionals against adverse effects from their work is not a new finding (Coster & Schwebel, 1997; Ennis & Horne, 2003; Iliffe & Steed, 2000; Mederios & Prochaska, 1988; Savicki & Cooley, 1987). For many helping professionals, support from their employer, colleagues, friends and family may mitigate the potentially negative effects of clinical work and reduce the sense of isolation associated with providing therapy. Social support is also likely to increase professionals' workplace satisfaction that again, may provide protection against experiences such as burnout or traumatic stress responses.

Future Directions

There are potentially many directions in which to continue this program of research. Additional qualitative data was collected from participants in the first empirical study presented in this dissertation. Participants responded to three open ended questions at the end of the Participant Questionnaire: What aspects of clinical work with your primary client population do you feel are traumatizing and/or contribute to the potential of traumatisation? What are the positive aspects that motivate you to continue to provide

counselling/psychotherapy to your primary client population? What do you do to cope with the personal and professional effects of working with your primary client population? This data was collected with the intention of conducting several concept-mapping investigations. In addition to clarifying the scope and domain of these professionals' experiences, these studies may also contribute to a better understanding of variables that may mitigate or contribute to traumatic stress responses, leading to further quantitative investigations.

Longitudinal research, however, seems to be the most logical step in clearly understanding how professionals can be impacted by providing counselling, and how these effects may change over time. Research that has been conducted to date in the area of vicarious trauma and traumatic stress among mental health professionals has largely focused on response to clinical work "in the moment" or closely following a traumatic event, such as September 11th, 2001. A longitudinal study that investigates responses to clinical work among mental health professionals throughout their career and exposure to providing counselling, may prove very valuable in forwarding our knowledge and developing a common understanding on how this work can affect us.

Conclusion

Existing research into the construct of vicarious trauma remains questionable and does not appear to provide an adequate basis for generalizing the phenomenon and planning for remedial strategies. The findings of this investigation do not lend support for the existence of a phenomenon that specifically results from professional exposure to the trauma of others, but do suggest that a minority of professionals may experience traumatic stress responses from their clinical work. The focus of future research on

vicarious trauma may be well served to shift focus away from the content and dynamics of therapy, toward the individual therapist. Individual and personality related variables should be investigated as to their importance in contributing to the experience of traumatic stress among professionals providing counselling. Few studies have commented on, let alone examined the personal distress of therapists, current psychological functioning, styles of coping and pre-existing psychiatric conditions as determinant factors in how professionals respond to their clinical work.

In conceptualizing the overall effect of providing psychotherapy on the professional, it is important to take into consideration the positive repercussions of clinical work. Aspects of reward, meaning and enjoyment that professionals commonly experience have been largely overlooked and unexplored. Further empirical investigation into both professional vulnerability and resiliency will benefit not only the helping professional, but also the many clients whose care can either be enhanced or hindered by the providers' ability to manage their responses to this demanding and gratifying work.

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APPENDIX A

Participant Letter

Michaela Kadambi

Dear Mental Health Professional:

I am an Educational Psychology Graduate student at the University of Alberta, currently working on my Doctoral Degree in Counselling Psychology. I am writing to request your participation in a research study investigating the personal and professional impact of providing counselling and psychotherapy.

You as a mental health professional, along with your colleagues, are familiar with the professional and personal challenges associated with the provision of counselling and psychotherapy. Little empirical research, however, has been undertaken to compare the effects of providing these services among professionals working with different client populations. By participating in this research project you have the opportunity to contribute to, and focus attention on an exceptionally important area of investigation. By undertaking this research, I hope to better our understanding of how working with different clientele impacts mental health professionals, thereby possibly assisting individuals and agencies in their efforts to promote healthy working environments.

Enclosed with this letter are five brief questionnaires; one asks for background information and the other four assess potential areas of personal impact. It should take you approximately **thirty minutes** to complete all measures. In efforts to assist in the development of the Traumatic Stress Institute Belief Scale, and establish normative data, anonymous participant scores on the measure and demographic information will be forwarded to Dr. Laurie Anne Pearlman, developer of the scale.

Your participation in this study is on a ***voluntary*** and ***confidential*** basis. All information obtained will remain confidential. In addition, only general overall group findings will be reported. No information that is specific to you as an individual or data that will identify a single institution/agency will be included in the discussion of the research findings.

It is my ultimate intention to publish the results generated from this research in scholarly journals. You will be provided, however, with a detailed summary of the results and direction to further publication information. Data that is collected from participants in this study may also be used in the future for additional research and publications not currently planned as part of my dissertation.

Your participation in this study would be greatly appreciated. Should you decide to consent to participate in this study, please complete all five enclosed measures and return them in the envelope provided. **This form may be kept for your own records. If you do not wish to participate, please mail the survey measures in the envelope provided and the materials will be recycled.**

If you have any questions or concerns, please do not hesitate to contact me (>>) or my university advisor (Dr. Derek Truscott >>).

Sincerely,

Michaela A. Kadambi, M.Ed.
Department of Educational Psychology
University of Alberta

It would be appreciated if you would complete and return the measures as soon as possible

Please return all materials if you do not wish to participate

Thank - you for your assistance

APPENDIX B

Participant Questionnaire

Participant Questionnaire

This questionnaire is designed to collect information about you as a mental health professional and details about the nature and setting of your work with specific client populations. All information obtained through this study will be kept confidential and you will return the completed measures anonymously.

<u>It is important that all questions are answered.</u>

<u>Please note that all measures are **DOUBLE SIDED.**</u>

Gender *(Please Circle)*

1. Male
2. Female

Age: _____

Highest Education Obtained:

1. Diploma/Certificate
2. Bachelors Degree
3. Masters Degree
4. Doctorate of Philosophy
5. Medical Degree
6. Other (Specify):
   _____

Professional Designation:

1. Therapist/Counsellor
2. Social Worker
3. Nurse
4. Psychologist
5. Psychiatrist
6. Pastoral Counsellor
7. Other (Specify):
   _____

1. **How long have you been engaged in the practice of counselling/psychotherapy?**

   Please specify number of years: _____

2. **Please specify your <u>primary client population</u> (the population that makes up at least 50% of your client case load).**

   1. I work primarily with clients affected by Cancer.
   2. I work primarily with clients affected by Sexual Violence.
   3. I do not work primarily with any one client population but see a range of clients with various issues.
   4. A combination of the above populations (Specify):
      _____

5. Other (Specify): _____

3. **Are you currently working with any client populations <u>other than</u> your primary client population?**

   1. Yes (Specify):

      _____

      Please estimate the percentage of your total counselling/psychotherapy time you spend with this population: _____

   2. No

4. **What percentage of your counselling/psychotherapy time is spent with your primary client population (identified in question #2)?**

   1. 1% – 25%
   2. 26% - 50%
   3. 51 % - 75%
   4. 76% - 100%

5. **How long have you been working with this primary client population?**

   Please specify number of years: _____

6. **What is your work setting when working with your primary client population?**

   1. Hospital
   2. Community Based Organization
   3. School/University
   4. Multiple Work Settings (Specify):

      _____

   5. Other (Specify):_____

7. **When working with your primary client population do you provide ***<u>mostly</u>*:**

   1. Individual and/or couple therapy
   2. Group therapy
   3. Provide individual and group therapy equally

8. **Have you ***<u>in the past</u>* **ever worked <u>primarily</u> (over 50% of your total client case load) with clients who experienced, witnessed or were confronted with events that involved actual or threatened death, serious injury or threat to the physical integrity of themselves or others?**

   1. Yes (Specify type of trauma):

      _____

      How long ago did you engage in this work?_____

2. No

9. **How much exposure do you feel you have to graphic and traumatic material presented by your primary client population?**

1. None at All
2. Minimal Amounts
3. Moderate Amounts
4. Profound Amounts

10. **How much exposure do you feel you have to descriptions of human cruelty in your work with your primary client population?**

1. None at All
2. Minimal Amounts
3. Moderate Amounts
4. Profound Amounts

11. **Have you received any specialized training to prepare you to work with your primary client population?**

1. Yes
2. No (**go to question #15**)

12. **How did you acquire this training?**

1. Training offered through employing institution/agency
2. Professional workshops or conferences
3. Through an academic institution
4. Other (Specify):_____

13. **Do you feel that the specialized training has adequately prepared you to work with your primary client population?**

1. Not at all
2. Minimally
3. Moderately
4. Profoundly

14. **Do you feel that the specialized training has adequately prepared you to deal with the feelings and personal reactions you may experience working with your primary client population?**

1. Not at All
2. Minimally
3. Moderately
4. Profoundly

15. Regarding your provision of counselling/psychotherapy, are you:

1. Currently supervised by a professional
2. Not currently supervised by a professional (**go to question #17**)

16. Does your supervision experience:

1. Address treatment issues in dealing with your primary client population
2. Address the personal and professional impact that working with your primary client population has on you as a treatment provider
3. Address both the personal impact of your work and treatment issues
4. Other (Specify):_____

17. Is there an available venue for you to address and explore the personal impact of working with your primary client population?

1. Yes
2. No

If you answered "Yes" to the above question, please specify how and with whom this is accomplished (on a general level, no identifying information is required):

1. Within Work Setting (Specify):

_____

_____

2. Outside Work Setting (Specify):

_____

_____

18. Have you ever addressed the personal effects of providing counselling/psychotherapy in your own personal therapy?

1. Yes
2. No

19. Have you yourself experienced a traumatic stressor in which you experienced, witnessed or were confronted with events that involved actual or threatened death, serious injury or threat to your or others' personal integrity?

1. Yes
2. No (go to question #21)

20. Please indicate the type of traumatic stressor you experienced (circle all that apply):

1. Sexual assault or child sexual/physical abuse
2. Domestic violence

3. War veteran
4. Other event not listed above that you feel was traumatizing (Specify):

_____

21. Would you describe the cumulative impact of providing counselling/psychotherapy to your primary client population as "traumatizing" or "potentially traumatizing"?

1. Yes
2. No **(go to question #23)**

22. What aspects of clinical work with your primary client population do you feel are traumatizing and/or contribute to the potential of traumatization?

_____

_____

_____

_____

23. What are the positive aspects that motivate you to provide counselling/psychotherapy to your primary client population?

_____

_____

_____

_____

_____

23. What do you do to cope with the personal and professional effects of working with your primary client population?

_____

_____

_____

_____

Thank – you for your participation in this research

APPENDIX C

Traumatic Stress Institute Belief Scale – Revision M

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APPENDIX D

The Impact of Event Scale

Impact of Event Scale

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you with ***regards to your work with your primary client population***, during the past 7 days. If they did not occur during that time, please mark the "not at all" column.

	FREQUENCY			
	Not At all	**Rarely**	**Sometimes**	**Often**
1. I have thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from memory.				
4. I had trouble falling asleep or staying asleep, because of pictures or thoughts about it that came to mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it was not real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

APPENDIX E

Maslach Burnout Inventory: Human Services Survey

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APPENDIX F

Spiritual Well-Being Scale

Spiritual Well - Being Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA	=	Strongly Agree	D	=	Disagree
MA	=	Moderately Agree	MD	=	Moderately Disagree
A	=	Agree	SD	=	Strongly Disagree

---

1. I don't find much satisfaction in private prayer with God. SA MA A D MD SD
2. I don't know who I am, where I came from or where I am going. SA MA A D MD SD
3. I believe that God loves me and cares about me. SA MA A D MD SD
4. I feel that life is a positive experience. SA MA A D MD SD
5. I believe that God is impersonal and not interested in my daily situations. SA MA A D MD SD
6. I feel unsettled about my future. SA MA A D MD SD
7. I have a personally meaningful relationship with God. SA MA A D MD SD
8. I feel very fulfilled and satisfied with life. SA MA A D MD SD
9. I don't get much personal strength and support from my God. SA MA A D MD SD
10. I feel a sense of well – being about the direction my life is headed in. SA MA A D MD SD
11. I believe that God is concerned about my problems. SA MA A D MD SD
12. I don't enjoy much about life. SA MA A D MD SD
13. I don't have a personally satisfying relationship with God. SA MA A D MD SD
14. I feel good about my future. SA MA A D MD SD
15. My relationship with God helps me not to feel lonely. SA MA A D MD SD
16. I feel that life is full of conflict and unhappiness. SA MA A D MD SD
17. I feel most fulfilled when I am in close communion with God. SA MA A D MD SD
18. Life doesn't have much meaning. SA MA A D MD SD
19. My relation with God contributes to my sense of well - being. SA MA A D MD SD
20. I believe there is some real purpose for my life. SA MA A D MD SD

APPENDIX G

Participant Letter

Michaela A. Kadambi, M.Ed.

May 14, 2001

Dear Treatment Provider,

I am an Educational Psychology Graduate student at the University of Alberta, currently working on my Doctoral Degree in Counselling Psychology. As part of an extension on the data collected for my Masters thesis, I am presently working on a research project to call attention to what professionals identify as positive aspects or rewards of working with sex offenders. By undertaking this research, I hope to better our understanding of what keeps professionals working with sex offenders motivated and rewarded by this difficult work. Much of previous research has focused on the difficulties these professionals face and yet there are many who feel highly rewarded and satisfied with the work they do.

I am writing to request your participation in a research study in which you will assist in the analysis of what Canadian therapists working with sex offenders identified as rewarding and motivating about their clinical work. Your participation will involve **completing a short demographic survey** and then **sorting 83 statements into piles**. You are then asked to **rate each of the statements in terms of their importance** to you. Using Concept Mapping methodology (a combined qualitative/quantitative methodology that assists in the clarification of an underlying structure of a phenomenon), the results of your participation will result in a Concept Map of overall themes from the statements you will have sorted.

Enclosed with this letter is a brief Treatment Provider Survey which collects demographic information and information about your work with sex offenders. Within the self-addressed stamped envelope you will also find 83 small statements for you to sort through and an instruction sheet for the sorting process. *Please take a moment and review these instructions*. It is estimated that this process will take about 30 minutes of your time.

Your participation in this study is on a ***voluntary*** and ***confidential*** basis. All information obtained as a result of your participation in this study will remain confidential. It is my ultimate intention to publish the results generated from this research in scholarly journals. However, once the data has been analyzed, I will forward to you a detailed summary of the results and direction to further publication information.

Should you wish to participate simply complete the ***Treatment Provider Survey***, the ***sorting of statements*** and the ***rating scale*** ranking the importance of the statements and return them in the self addressed stamped envelope.

Your participation in this study would be greatly appreciated. If you have any questions or concerns, please do not hesitate to contact me (Michaela Kadambi or

or my university advisor, (Dr. Derek Truscott
>>).

Sincerely,

Michaela A. Kadambi, M.Ed.
Department of Educational Psychology
University of Alberta

It would be appreciated if completed measures could be returned as soon as possible.

Thank - you for your participation!!

APPENDIX H

Treatment Provider Survey

Treatment Provider Survey

This questionnaire is designed to collect information about you as a treatment provider, and details about the nature and setting of your work with sex offenders.

It is important that all questions are answered

All information obtained through this study will be kept confidential, and you will return the completed measures anonymously. Thank - you again for your assistance in this study.

Demographic Information

Age: _____

Gender *(Please circle)*

1. Male
2. Female

Highest Education Obtained

1. Diploma/Certificate
2. Bachelors Degree
3. Masters Degree
4. Doctorate of Philosophy
5. Medical Degree
6. Other: Specify _____

Professional Designation:

1. Therapist/Counselor
2. Social Worker
3. Nurse
4. Psychologist
5. Psychiatrist
6. Correctional Officer
7. Probation/Parole Officer
8. Other (Specify):_____

Information Regarding Work & Work Setting

1. **How long in total have you been practicing as a mental health professional?**

   _____(specify years)

2. **How long have you been working with sex offenders?**

   _____ (specify years)

3. **What is your work setting regarding sex offenders?**

   1. Hospital
   2. Correctional Institute
   3. Community Based Program
   4. Multiple Work Settings
   5. Other (Please specify)_____

4. **Within your work setting do you work with sex offenders *mostly*:**

   1. On an individual basis
   2. In a group setting
   3. Work equally between individual and group settings

5. **Regarding your work setting with sex offenders, do you provide therapeutic treatment within what may be considered:**

   1. An *intensive treatment* program (usually residential program of more than 8 months within a specialized treatment facility/organization)
   2. An *intermediate intensity* treatment program (usually non-residential program offered within a general institution/agency)
   3. A *low intensity* treatment program (typically relapse prevention type programs offered through minimum security institutions or community based agencies)
   4. Combination (Please specify)

      _____

   5. Other: (Please specify)

      _____

6. **Regarding your work with sex offenders, do you work *mostly* with:**

   1. High Risk Offenders
   2. Moderate Risk Offenders
   3. Low Risk Offenders
   4. Special Needs Offenders
   5. Combination (Please specify): _____

APPENDIX I

Sorting Instructions

Sort Instructions

1. Please read through the 83 slips of paper and sort them into piles according to how they seem to go together. Please note: You may or may not have experienced what is described on the slip of paper.

2. Place similar statements together in the same pile.

3. You can have as many piles as you want, but you cannot have only one pile, and you cannot have 83 piles.

4. If you believe that a statement is unrelated to all of the others you may place it in its own pile.

5. There are no right or wrong groupings. You are to choose the way that seems best to you.

6. *PLEASE STAPLE* the slips that make up each individual pile together.

7. Complete the Treatment Provider Survey and enclose each *STAPLED PILE* in the envelope addressed to the researcher and return materials.

Thank – you for your assistance

APPENDIX J

Participant Rating Instructions

The following statements were derived from therapists who work with sex offenders about what they find rewarding about their work. Please place the number that best describes ***how important*** it is to you on the blank line beside each statement using the scale below. Please return this form to the researcher via email or in the envelope provided.

1 = Not Important
2 = Somewhat Important
3 = Moderately Important
4 = Very Important
5 = Extremely Important

1. To reduce the chance of the offender hurting anyone else. _____
2. I feel that I have helped these clients. _____
3. Seeing men engaging positively in treatment over the long term. _____
4. Breaking the cycle of abuse. _____
5. Upholding belief that treatment for sex offenders can be effective. _____
6. Witnessing improvement in someone's quality of life. _____
7. Protecting the community. _____
8. Providing education about the myths of sexual abuse/ sexual offending. _____
9. Seeing the offender as a person and not a perpetrator. _____
10. I was able to work with a co-facilitator whom I greatly respected. _____
11. There is a large degree of autonomy associated with the work. _____
12. My colleagues are knowledgeable, ethical and industrious people. _____
13. We are a well functioning team. _____
14. To reduce the possibility of more victims. _____
15. To reduce the incidence of sexual abuse. _____
16. Being part of the metamorphosis of change and accountability. _____
17. It is challenging work. _____
18. Helping offenders to live productive lives. _____
19. To give offenders a better sense of control over their offending. _____
20. Promotion of safety to the public. _____
21. I get feedback that the things I do help these clients. _____
22. The money is good. _____
23. Watching our clients change over treatment. _____
24. Seeing who offenders can become. _____

25. The feeling that if one victim can be prevented, it will all be worthwhile. _____

26. The realization that sex offenders are real people capable of change. _____
27. Seeing offenders' improve their lifestyles. _____
28. I enjoy counselling. _____
29. I enjoy teaching. _____
30. I receive good financial compensation. _____
31. Dealing within an area which has profound and reaching effects on others. _____
32. These men have a chance to turn their lives around. _____
33. I have some patients assigned to me who are motivated to change. _____
34. I receive positive feedback from members of my treatment team. _____
35. I am paid well with good benefits. _____
36. Work assists the offender to recognize crime cycle and prevention strategies. _____
37. I make a difference in my community. _____
38. Having an offender move away from denial and minimization. _____
39. Seeing offender gain understanding of the effect the offense has on their victims. _____
40. Offenders can learn that control is possible. _____
41. Participating in a professionally cutting edge program of sex offender treatment. _____
42. The honor of being party to the transformation of souls. _____
43. It requires engagement of intellectual, spiritual social and psychological issues. _____
44. The opportunity to work with other dedicated staff. _____
45. Being able to observe and participate in others making life changes. _____
46. Helping them heal. _____
47. My motivation is to make my family safer. _____
48. No one else will do it. _____
49. I believe in CSC mandate to reduce the risk of re-offence through treatment. _____
50. Ability to design assessment and treatment programs the way that I feel is best. _____
51. Ability to focus on an area of specialty and become an "expert" in the field. _____
52. Offenders can come to recognize their unhealthy lifestyle cycles. _____
53. Excellent colleagues in the field. _____
54. I enjoy the therapeutic contact with these clients. _____
55. Great exposure to real pathologies and disorders. _____
56. These clients bring out the best in me. _____
57. The phone calls and letters from ex – offenders doing well in the community. _____
58. The co-workers in my team are excellent to work with. _____

59. I feel I can make a difference. _____
60. I find clinical and research related activities with this population fascinating. _____

61. Seeing people excited about learning about themselves and transforming. _____
62. For the experience I gain. _____
63. I get to work with an incredibly talented pool of people. _____
64. I feel that my clinical skills are challenged to the fullest with these clients. _____
65. Variety and flexibility in my work schedule. _____
66. I feel that I am doing something very worthwhile. _____
67. It is rewarding to see clients taking responsibility for their offence. _____
68. Watching the progress to more prosocial individuals. _____
69. Our program has a low recidivism rate. _____
70. To see someone succeed in their struggle to change. _____
71. These clients are more secretive and more in denial, therefore it becomes a game of lowering these barriers – the "game" is exciting. _____
72. Intervention can result in a healthy individual. _____
73. The support of the treatment team. _____
74. I feel I have had a positive impact on the lives of individuals I have worked with. _____
75. Being able to correct some of the public misperceptions that hinder successful management of sex offenders. _____
76. I have encouraged other agencies to provide awareness towards prevention of sex offending/sexual abuse. _____
77. Our program is successful in terms of completion. _____
78. Teaching and learning from colleagues. _____
79. Finding ways to demonstrate effective treatment. _____
80. I work with highly motivated co-workers. _____
81. This work brings status and access to program funds. _____
82. I am close to the cutting edge of research. _____
83. The inspiration and encouragement I feel from other dedicated colleagues. _____

THANK YOU FOR YOUR ASSISTANCE!!

(All participants will receive a summary of results once they become available)

APPENDIX K

Ethics Review Form

FACULTIES OF EDUCATION AND EXTENSION
RESEARCH ETHICS BOARD

Graduate Student Application for Ethics Review

Name Michaela Kadambi Student ID

E-mail:

Project Title: An Investigation of Vicarious Trauma Among Mental Health Professionals Working With Survivors of Sexual Violence, HIV/AIDS, and Cancer.

Project Deadlines:

Starting date February 2000 Ending date September 2000 (data collection complete) (September, 2001 – dissertation complete)

If your project goes beyond the ending date, you must contact the REB in writing for an extension.

Status:

___ Master's Project ___ Master's Thesis _X_ Doctoral Thesis ___ Other_____ (Specify)

The applicant agrees to notify the Research Ethics Board in writing of any changes in research design after the application has been approved.

Signature of Applicant — January 7 /2000 19___ Date

The supervisor of the study or course instructor approves submission of this application to the Research Ethics Board.

Signature of Supervisor/Instructor — Jan 13 /2000 19___ Date

ETHICS REVIEW STATUS

___ Application not approved

✓ Expedited review approved by Unit Statutory member/Alternate

___ Review approved by Research Ethics Board

Signature of REB Member — February 27, 2000 19___ Date